RELOCATION STRESS EFFECTS AND THE ELDERLY: IMPLICATIONS FOR SOCIAL WORK PRACTICE AND LONG-TERM CARE POLICY

by

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INTRODUCTION

Considering the enormous cost and the high degree of institutionalization among Canada and British Columbia's older population indicates that delineations among the elderly and the conditions that surround relocation and institutionalization must be made to alleviate the deleterious effects of relocation stress.

The realization of these objectives are crucial in view of the fact that an extensive body of relocation stress studies and their findings clearly demonstrate the negative effects that relocation can pose for the elderly. The relocation experience has been found to be related not only to decreased health and psycho-social functioning, but also to increased rates of mortality and morbidity. In addition, the experience of relocation is potentially stress inducing not only for the elderly, but for their families who may have an aging parent(s) or relative requiring institutional placement. These are problems which affect the well-being, life satisfaction and adequate functioning of an increasing number of people. Such concerns demand an obligation from society, as well as a concomitant of the health system, to direct and guide the development of further research, practice and policies aimed at minimizing the risk of relocation.

After examining the effects of relocation stress found in the literature, I propose to consider the implications for
social work practice as well as implications for long-term care policies. Thus, the purpose of this paper is threefold. The first section will briefly outline the research studies, findings or conditions that have been identified and related to either promoting or hindering effective relocation. Many of the research studies and their implications have a direct bearing and relevance for determining current and future policy and practice development for helping the elderly successfully adjust to institutional settings.

Drawn from personal experience of work with the elderly in an acute care hospital, a home for the aged, and from my understanding of the literature concerned with relocation stress, the second section will focus on strategies and interventions that have been found useful and which merit consideration by health workers and professionals for mitigating the observed adverse effects. The predominant focus will concern the relocation of the elderly from the community to institution, as well as those elderly who are rerouted or admitted to old age institutions via the acute care or general hospital. Where appropriate, other moves between and within institutions will also be included.

The rationale for focusing primarily on the population who move from the community or from acute general or allied hospitals rests on the assumption that these moves incur the
greatest degree of change or disruption. Accordingly, these transitions elicit and reflect an increasing concern for facilitating and devising more effective and innovative policies and procedures for relocating the elderly at risk.

Thus, the latter section of this paper will suggest implications for long-term care policies, often paralleling the objective for actualizing effective relocation practice and outcome.
LITERATURE REVIEW

A. Definition of Terms

In the relocation stress literature, relocation has generally been defined as the change in environment that occurs when an individual moves from one location to another (Hasselkus, 1978). Numerous researchers have viewed the relocation process as a sequence of stages beginning with situational or life change events that precipitated the move and ending several months after relocation or following a period of adjustment (Pope, 1978; Tobin and Lieberman, 1976). Recently, there has been considerable concern about the stress effects that may be produced by relocation and life changes in the stress literature. Unfortunately, the term, "stress," has been difficult to define. Therefore, it is important to know what is meant by the term, "stress," and how it is conceived in the literature.

The pioneering work of Holmes and Rahe (1967) reflecting a life change approach to stress identified that discrete changes in life patterns could create stress. Their research with United States navy personnel suggested that the significance of stressful events demands adaptation which in itself is costly to the organism as demands increase. These researchers found that persons who had been exposed to occurrences of life-change events were more susceptible to
an onset of physical or mental disorders. Essentially, "stress" has been used to refer to the adjustive demands made upon the individual (Coleman, 1973:169). As well, "stress" has been used to refer to a situation that causes an individual to react as though he/she has been threatened. The stressful situation may be a physical, social or cultural condition which induces discomfort in the individual (Mechanic, 1973:91).

On a psychological level, research describing an individual's reaction to environmental events and life stress has also been advanced by the work of Engel, Schmale et al., (1970); Seligman (1975); Langer (1979); and Langer and Benvento (1978). Their respective concepts of "the giving up syndrome," "learned helplessness," and "self-induced independence" have been suggested to partially account for the adverse psychological traits and adjustment difficulties of the institutionalized elderly.

The way in which stress has been linked to somatic illness has also been widely recognized in recent years. The foundation for systemic research originated with the work of Cannon (1929) who showed that stimuli associated with emotional arousal caused changes in basic physiological processes. Further impetus for systemic study also arose from Hans Selye's classic work demonstrating how physical and psychological stressors may lead to "diseases of adaptation" or the syndrome he described as "just being sick" (Selye,
1956). Selye defined stress as "the non-specific response of the body to any demand made upon it" (p. 27).

In summary, the concept of stress has usually been examined or studied on three levels of analysis, namely: social stress concerned with the disruption of social units or systems; psychological stress, with cognitive variables leading to the evaluation of threat; and systemic or physiological stress concerned with tissue disturbances. It has generally been recognized that stressful life events, such as relocation, "plays a role in the etiology of various somatic and psychiatric disorders and may pose a threat to health" (Dohrenwend and Dohrenwend, 1973:1). In this sense, stress is conceived as an event in the environment and not as a state of the total organism.

While looking at stress in this way is valuable, there has been a lack of consensus or clarity in developing a concise, but comprehensive, definition of stress. For purposes of this paper, Lazarus' definition of stress will be adopted and defined "as a generic term for the whole area of problems that includes the stimuli producing stress reactions, the reaction themselves, and the various intervening processes" (Lazarus, 1966:27). As a result, the field of stress will encompass the physiological, psychological and sociological phenomena and their respective concepts. To elaborate further, the arena to which stress refers "consists of any event in which environmental demands, internal demands
or both, tax or exceed the adaptive resources of an individual social system, or tissue system" (Lazarus, 1966:3).

B. The Rate of Institutionalization

The effects of relocation stress on the aged has been a recent concern, with over two hundred studies devoted to the examination of this phenomenon. Among the reasons for this rising interest in the well-being of the elderly is their rapid increase in absolute numbers, their increasing proportion to the total population, and in the high rates of institutionalization.

Unfortunately, Canada has the major distinction of institutionalizing more than 8.4 percent of those over sixty-five in some type of quasi-institutional setting in comparison to the United States where only 5 or 6 percent and the United Kingdom where only 5.1 percent of the elderly are institutionalized (Schwenger and Gross, 1980). Within the Province of British Columbia as of May 1, 1980, 7.8 percent of the elderly over sixty-five were housed in some form of care facilities. Of these, 16,312 were in intermediate care facilities, while 5,500 were in extended care facilities (Long-Term Care Statistics, Victoria, September 1980). In addition, a further 2,811 beds will be available before 1982 (Ministry of Health Annual Report, 1979) to provide a continuum of institutional care.

Besides a growing realization of the high personal, social and human waste of resources in institutionalizing our elderly,
interest has also been stimulated in part by the high expenditures of public and private dollars involved. For example, projections from Canada's hospitals over the next five years include a tripling in demand for health care facilities by a rapidly expanding elderly population (Statistics Canada, Population Projection, 1980).

The above figures provide ample testimony to the high rate and demand for institutional care among Canada's elderly population. For the elderly, relocation — particularly from the community to an institutional setting — is a stress-provoking experience (Lieberman, 1961; Costello and Tanaka, 1961; Tobin and Lieberman, 1976). A considerable body of research (Aldrich and Mendkoff, 1963; Markus et al., 1971; Bourestom and Tars, 1974; Killian, 1970) suggests that relocation entails considerable risk in terms of increased mortality and morbidity rates. As well, studies have shown that ensuing stress from relocation can pose considerable problems for those who survive relocation in terms of psychological, physiological and social functioning (Dohrenwend, Dohrenwend, 1973; Bourestom and Tars, 1974; Brand and Smith, 1974; Tobin and Liberman, 1976).

C. A Summary of Relocation Stress Studies

Historically, relocation studies have overwhelmingly been preoccupied with mortality rates in assessing the impact of relocation stress (Borup, et al., 1980:468). At least
half a dozen studies have found that relocation resulted in an increase in mortality rates (Aldrich and Wendkoff, 1963; Markus, Blenkner, Bloom and Downs, 1972; Bourestom and Pastalan, 1975; Jasna, 1967; Killian, 1970; Markus et al., 1971; Marlow, 1972). On the other hand, more than a dozen studies have found no significant effects on mortality rates (Borup, et al., 1979; Bourestom and Pastalan, 1975; Lawton and Yaffe, 1970; Markson and Cummings, 1975; Markus et al., 1971; Miller and Lieberman, 1965; Pino et al., 1978; Wittels and Botwinick, 1975; Zweig and Csank, 1975). To further confuse issues, several studies found a lower death rate in a relocated group. For example, Carp (1966), Lawton and Yaffe (1970), and Markus et al. (1971) found generally favorable results. Needless to say, the study results are often conflicting and somewhat confusing.

To begin to make sense of inconsistent research findings that use mortality as a criterion for determining the effects of relocation, one must question and examine the research design used, including the population sampled, the type of move studied, the conditions under which the move took place, and other variables that might affect the results.

Types of Moves Studied

In the relocation stress literature, studies have primarily focused on four types of moves or transitions, namely: moves from the community to institution, inter and intra-institutional moves, and moves from one building to another.
Given that relocation is thought to be a generally stressful experience, one must examine the quality of moves studied in terms of assessing the effects of relocation stress.

An increasing concern regarding the elderly relocating from the community to institution has arisen because these moves appear to entail the greatest risk. It is believed that the elderly experience a more radical environmental change which, in turn, has been related to destructive physical and adverse psychological effects (Aldrich and Mendkoff, 1963; Blenkner, 1967; Ferrari, 1963; Tobin and Liberman, 1976). Furthermore, those elderly facing pending institutionalization often anticipate placement with fear and dread, as well as an accompanying loss of social and personal status and/or a general disruption of their previous lifestyle.

In the stress literature, three notable studies have demonstrated that relocation from community to institution has proved lethal for relocated elderly (Blenkner, 1967; Ferrari, 1963; Costello and Tanaka, 1961). Blenkner (1967) introduced one of the few controlled studies by randomly allocating non-institutionalized aged to one of three community service programs ranging from "minimal" service to a "medium" intensive service to an "intensive" direct service provided by social workers and public health personnel. Unfortunately, the sample size negated a significant study of the effects noted. At a six-month follow-up, the mortality
rate was considerably higher for those elderly involved in the "maximum" service program (24 percent), while those on the "midway" and "minimal" service program experienced a death rate of 12 percent and 6 percent, respectively.

Costello and Tanaka (1961) also reported a higher mortality rate of 38 percent in the first six months of institutional placement in contrast to a reported death rate of 11 percent for those elderly who were on an institutional wait list during a one-month period. Ferrari (1963) also reported a dramatically high mortality rate for elderly who moved from community living to an institutional environment.

Although these study findings lead one to conclude that community to institutional moves may result in increased mortality rates, the study designs and research methodology are open to a variety of interpretations. For example, the study by Blenkner, although using a random sample, was not large enough to justify any firm conclusions about the differential mortality rates. In the last studies cited by Costello and Tanaka (1961) and Ferrari (1963), both compared wait listed and post admission mortality rates which ruled out self-selection or random sampling. As well, the study design posed related problems since a comparison of the elderly who had been admitted to an institution with a wait listed group was not necessarily valid. It is likely that those who required facility care were more unhealthy; thus, it is predictable or expected that they should reflect a higher death rate (Rowland, 1977:357).
In the study by Costello and Tanaka (1961) when the rates were adjusted to compare equal time periods between those on the wait list and those subjected to institutional placement, the results showed that the death rate was more likely to occur during the waiting period than it did after admission (Kasl, 1977). The waiting period has, in fact, been shown to be one of stressful anticipation which may partially account for the observed effects (Tobin and Lieberman, 1976). Still, an association between death and general health deterioration has been linked with entrance to an institution.

Research studies concerning the effects of other moves, such as inter-institutional, or en-masse moves, or moves from building to building, often pose fewer problems in research. First of all the problem of initial differences in health status between controls and experimental groups is reduced. Possible institutional effects on the individual and affecting mortality rates are also diminished.

Generally, two types of research methods have been utilized to establish a relationship between inter-institutional relocation and mortality rates: an experimental control design in which mortality rates of movers are compared to mortality rates of elderly who do not move; a baseline design in which mortality rates prior to relocation are compared with mortality rates after relocation. One of the better studies was done by Killian (1970). He used an experimental control design
where controls were matched with relocated patients on six variables (i.e., age, sex, race, diagnosis, length of hospitalization and ambulation abilities). His stronger research design, unlike many others, provides convincing evidence regarding the association between death and relocation.

Other researchers have used a baseline design to compare mortality rates before and after transfer (Aldrich and Mendkoff, 1963; Markus et al., 1971; Zweig and Csank, 1975; Gutman and Herbert, 1976). In the majority of these studies, mortality rates increased following relocation from one institution to another. However, Borup et al. (1979) have criticized the use of a baseline approach because of the difficulty of establishing a valid matching or comparable baseline of groups being relocated. As well, the study findings are open to interpretation since the receiving environments may not have been comparable to the former and/or admission and health care factors may have tended to bias the results.

In the Zweig and Csank study (1975), the researchers found a decrease in mortality rates which may have been attributed to extensive use of a preparation program. However, convincing data concerning the effects of environmental change of the elderly comes from studies of institution to institution moves (Kasl, 1977: 95).

Not only community to institution or inter-institution moves create distress and trauma for the elderly. Other
studies support the fact that relocating the elderly from one ward to another or within the same institution can also promote adverse effects (Aleksandrowicz, 1961; Jasnau, 1967; Pablo, 1977). Although methodological concerns are also relevant in interpreting these studies' results, there is an increasing acceptance that "intra-institutional transfers can result in perceptible changes in the patients' living patterns that can influence survival and overall physical and mental levels of functioning" (Pablo, 1977:434).

Health and Social Adjustment

There are fewer studies which are directly concerned with the psychological and health consequences of relocation since those effects pose considerable methodological and interpretational problems for researchers. As well, few studies are available which use either an experimental design control and/or a longitudinal design (George, 1980:116). However, two longitudinal Canadian studies done by Kraus, Spasoff et al. (1978a) demonstrated changes in health subsequent to relocation from community to institution. Although Kraus et al (1978) reported improvements in health among institutional residents one month after moving, a long-term observation showed that relocated subjects experienced a significant deterioration in their general health status. In a similar study, conducted by Tobin and Lieberman (1976), these researchers found comparable results. Other studies examining the effects of relocation and health in inter-
institutional moves (Bourestom and Tarb, 1974; Pino, Rosica and Carter, 1978) report that these moves also are accompanied by declines in health.

In terms of the effects on psychological and social aspects of individuals, study findings are suggestive but inconclusive. Possibly, the most convincing data or evidence for supporting the contention that relocation has a negative impact on self-concept and self-esteem have been provided by Tobin and Lieberman (1976). In their well-known studies of community residents who moved to an institutional setting, their findings strongly suggested that relocated elderly were characterized by lower levels of self-esteem prior to and after institutionalization (in contrast to individuals who remained in the community). However, it is still not clear whether the adverse effects reported are due to the process of relocation itself, or to the loss of health status and general assaults of aging (George, 1980:118).

Because of contradictory findings in these studies, there is reason to suspect that other variables are involved that may be influencing how relocation affects older persons.

D. Conditioning Variables

Recent studies of the effect of relocation stress have utilized more sophisticated empirical research designs and methodology. In a review of the literature, Bourestom and Pastalan (1981) suggest that the nature of current studies no
longer question "whether relocation has negative (or positive) effects, but under what conditions and with what kinds of populations are those negative or positive effects most likely to be observed" (p. 45). Information is accumulating which indicates that the way the move is organized or handled may affect how an individual copes with the move (Bourestom and Pastalan, 1981; Jasnau, 1967; Novick, 1967).

Unfortunately, most preparation programs have focused exclusively on inter-institutional moves (Gutman and Herbert, 1976; Markus, Blenkner, Bloom and Downs, 1971; Novick, 1967; Pino, Rosica and Carter, 1978; Zweig and Csank, 1975). These programs have tended to ensure that the resident was as involved as possible in decisions about the move, selection of room, and roommates, etc. Before the actual move, all residents were encouraged to become familiar with the new institution beforehand. As well, counselling family and supportive friends were resources used to alleviate fears and anxieties about the move. Lastly, the program culminated in the unpacking of their possessions by residents to help them feel at home.

These studies, reporting low mortality rates, have been criticized on the basis that the move of residents from one facility to another is not so different or radical. As Morton.Lieberman (1974) states: "Relocation is a risk to the individual not because of the symbolic meaning that such transitions imply, but because it entails radical changes
of the life space of an individual that require new learning for adaptive purposes" (p. 497).

The findings of Bourestom and Tars (1974) are also relevant. These researchers conceptualize that relocation is more harmful in moves where there is a radical environmental change that may overload the old person's adaptive capacities. As well, there are divergent views on whether the stress of relocation is partially due to the loss of familiar stimuli or from the trauma of new stimuli (Markus et al., 1971). Most importantly, Bourestom and Tars (1974) contend that "preparation programs should become mandatory policy in all situations which contemplate radical and involuntary relocation of elderly individuals" (Bourestom and Tars, 1974, 509).

Although most of the preparation programs have been developed for en masse transfers where the previous environment was similar to, or an improvement upon, the receiving environment, few post preparation programs have been devised to help the elderly adjust after admission. Grant and Gutman (1980) are the only researchers, I am aware of, who have devised a post preparation program. From my experiences in helping the elderly relocate to an intermediate care facility, I am strongly convinced of a need for such programs. As Grant and Gutman suggest, post preparation is needed particularly in those moves which incur the greatest degree of change (i.e., community to institution transitions). Most
preparation programs focus on the pre-move period, but intervention is needed to help individuals cope once they are in the institution. In view of the fact that the first three months pose the greatest threat to successful adjustment, (Bourestom and Tars, 1974; Miller and Lieberman, 1965), it seems logical that preparation should encompass the major stages of relocation.

The implementation of preparation programs is based not only on common sense, but also on theoretical assumptions that individuals wish to have control over their personal environment. Institutionalization of the aged represents an abrupt loss of personal control that results in feelings of hopelessness, helplessness, and depression (Seligman, 1975:185). More serious consequences may ensue as a result of perceived loss of control. Seligman (1975) states: "We should expect that when we remove the vestiges of control over the environment of an already physically weakened human being, we may well kill him" (p. 186).

A component of the "grey" institutionalized portrait has been an observation that residents tend to lose interest in the outside world, and learn to become passive and dependent. This is not entirely disadvantageous to the institution, since it is much easier for the staff to deal with a passive individual than one who is encouraged to be as independent as possible. Research supports the position that dependent behaviour is likely to be reinforced while
independence may be ignored (Barton, Baltes and Orzick, 1980). The proposal by Grant and Gutman (1980) to assess the functional and coping skills of new residents to be used as an evaluative tool for goal setting for the relocatee and institutional staff holds interesting and hopeful promise.

Variables Identified Which Mitigate the Relocation Effect

Factors found that help reduce negative effects and have been integrated into most preparation programs. The provision of opportunity for choice, (Ferrari, 1962), positive attitudes toward the move (Pino, Rosica, and Carter, 1978), and careful individualized preparation for moving through counseling and orientation to the new facility have proven to be important factors.

Other factors which appear to mitigate the potentially lethal risk include reducing the degree of social and physical discontinuity between the old and new environments (Bourestom and Tars, 1974), the degree to which the older person participates in the decision-making process, leading to institutionalization (Carp, 1967; Lawton and Yaffe, 1970; Ferrari, 1967; Beaver, 1970) and the voluntary/involuntary nature of the transition (Ferrari, 1967; Schulz and Brenner, 1977). As well, factors, such as the characteristics of the relocatees, are also associated with both positive and negative relocation effects. Researchers have identified
age, poor physical health and a psychological pattern of coping characterized by passivity, hopelessness, helplessness and depression as factors positively associated with risk (Aldrich and Mendkoff, 1963; Blenkner, 1967). In contrast, those with angry, aggressive assertive or narcissistic personalities are more likely to successfully survive relocation (Tobin and Lieberman, 1976; George, 1980:120).

Figure 1 is a diagrammatic presentation of some of the major variables which need to be considered in understanding the effects of relocating the elderly to institutional settings. The diagram is for illustrative purposes only and is not intended to suggest that these are all of the variables which influence the process of relocation and the subsequent outcome. The basic notion of the diagram is that there is a direction of influence from left to right, and that at any one intersection the "conditioning variables" may modify or mediate the process and outcome. Similarly, if there is a relationship from the physical environment or antecedent conditions conducive to stress, to physical and mental health and social functioning (outcome), then the process can best be understood if one takes into consideration the objective environment, the individual's interpretation of his environment, and the mediating processes which include the physiological, affective and behavioural reactions (Kasl, 1977:106).
Figure 1 - A Di臝graphical Presentation of Major Classes of Variables in the Study of Effects of the Residential Environment on Health and Behavior.
Similarly, a variety of characteristics of the person and his situation must be understood to determine how the process can be altered or modified. For instance, the way individuals cope and adjust would be dependent on whether they altered some aspect of the precipitating stressful conditions, whether they improved their skills, or whether they changed their subjective perceptions, and so forth.

The diagram has been adapted from a theoretical framework presented by Kasl (1977). Although the diagram is a very limited and somewhat arbitrary statement of the overall relocation stress process, it serves the purpose of providing a more systematic guide for understanding the complexity of the variables involved which may affect the health and behaviour and the subsequent adjustment of the institutionalized elderly.

E. The Study of Institutions

In addition to preparation programs and conditioning variables, the institutional environment has also been identified and related to adjustment and stress of the elderly newly admitted to care facilities.

In British Columbia, there are approximately 700 existing facilities to provide a range or continuum of institutional care from minimal supervision and assistance with activities of daily living to extensive medical and skilled nursing care (Ministry of Health: Annual Report, 1980).
In the relocation stress literature, it is generally assumed that the experience of relocation of the elderly is associated with deleterious somatic and psychiatric disorders. The typical institutionalized personality and other adverse traits are well documented in the literature. As well, the move or transition can result in the death of the elderly. However, what part does the institutional environment contribute to these negative effects?

After thirty years of research in the field of gerontology, Lieberman (1969) reports the following depressing portrait of the aged in institutions: (p. 330)

They share the following characteristics: poor adjustment, depression, and unhappiness, intellectual ineffectiveness because of increased rigidity and low energy (but not necessarily intellectual incompetence), negative self-image, feelings of personal insignificance and impotency, and a view of self as old. Residents tend to be docile, submissive, show a low range of interests and activities, and to live in the past rather than the future. They are withdrawn, and unresponsive in relationship to others. There is some suggestion that they have increased anxiety which at times focuses on feelings of death. (There are) marked increases in mortality rates for aged persons entering mental hospitals and homes for the aged.

Although these characteristics cannot be wholly attributed to the institutional environment since some of the effects may be due to selection biases of the population or to the institutionalization process, still there is evidence to strongly suggest that in many institutions the environment is conducive to deleterious effects for the institutionalized elderly (Brody, 1974:42; Tobin and Lieberman, 1976:23).
In answer to the question regarding what aspects or characteristics of the institution affect the elderly individual, Goffman's classic work, *Asylums*, offers a powerful analysis in an attempt to identify the effects of institutionalization in organizations such as prisons, hospitals, and homes for the aged and disabled. He suggests that institutions have an encompassing "total" feature which is dictated by the organizational staff and which is symbolized by barriers of interaction with external society (Goffman, 1961:4). The handling of many human needs by the bureaucratic organizations of whole blocks of people is central to his theory. Since Goffman was dealing with the diversity among organizations, individual institutions must be viewed with more flexibility. However, his general theory of total institutions has been applied to homes for the aged.

Similarly, a study by Kahana and Coe (1969) of 33 residents in a Jewish home for the aged found that the elderly were able to adapt where there were minimal formalized, clear and unambiguous rules. Although the sample used was small, it seems logical that an institutional environment providing a less structured or rigid setting would be conducive to enhancing adjustment and autonomy.

Many of these ideas can be applied to long-term care facilities for the aged in Canada. Degrees of ritualism and standardization, rifts between staff and resident
populations, role deprivation, are prevalent characteristics of our homes for the aged and our health care institutions in general.

Research studies concerned with the effects of institutionalization on various inmate populations—psychiatric, hospital, and handicapped patients—have revealed similar deleterious effects (Townsend, 1962:329). The effects of loss, deprivation and distortion of relationships on young children have also been generalized to long-term care of the elderly in understanding identifiable "symptoms" of institutionalization (Brearley, 1977:52; Townsend, 1962:335).

A contrasting perspective has been argued by John F. Myles, a sociologist at Carlton University. Myles argues that institutionalization provides the elderly with relief from poverty, illness and social isolation. He supports this argument with research studies demonstrating that the most significant correlates of life satisfaction and morale is the provision of relief from the preceding assaults of aging mentioned (i.e., poverty, illness and so forth). Thus, institutionalization is beneficial rather than detrimental (Myles, 1980:264). Like Goffman, his theory has been criticized on the basis that a number of other dimensions are also of paramount importance and that variations or differences among institutions must also be considered.
What variables or characteristics of the institution should we be focusing on in order to mitigate the effects of relocation stress and subsequent adjustment of residents? The study of changes in the recently institutionalized elderly becomes the selection of effects of institutional life from other factors of the environment and the process of institutionalization. A brief look at past research will reflect some of the different dimensions that researchers have found useful when studying institutional effects and adaptation.

One of the earlier attempts, using a few dimensions to assess the extent to which a setting was institution-like, was done by Kleemier (1963). He isolated three dimensions which, he believed, were related to the lifestyle of elderly institutional residents: (1) segregate dimension: a continuum at one end of which older people live exclusively among their age group, and at the other end they are with people of all ages; (2) non-institutional dimension: the imposition of rules, regulations, etc., and (3) the congregate dimensions: group size, closeness of individuals and a degree of privacy.

In an attempt to refine Kleemier's multi-dimensional approach, Pincus (1968) developed a framework for studying institutional environments in homes for the aged. He identified four dimensions of the institutional environment as: (1) public versus private; (2) the structured-
unstructured dimension; (3) resource sparse versus resource rich: the degree to which the environment permits the resident to engage in meaningful activities and roles other than that of patient, and (4) the isolated versus integrated: the degree to which the resident is able to interact with the outside community. Pincus stressed the need to study the relationship of these environmental dimensions to each other as well as the self-report or perceptions of the residents' satisfaction or dissatisfaction with his environment.

A secondary analysis by two researchers, Penning and Chappel (1980), based on a study conducted by the Manitoba Department of Health and Social Development in 1971, was initiated to test the adequacy of using an approach which considers only a few dimensions. These researchers concluded that "perceptions of well being among the institutionalized do not appear conditioned by single defining characteristics of the institutional environment" (p. 278). As well, they concluded that neither bureaucratic organization or the degree of totality or the provision of relief were adequate in explaining the experience of institutionalization of the elderly. They further concluded that only autonomy in choice of residence was significant in supporting those factors identified by Kleemier (1961) and Pincus (1968). Of particular interest is their finding that not only autonomy but perceptions of health, economic security and social
support and interaction are also related to perceptions of well-being (p. 278).

Therefore, their study results have implications for future policy and planning. In view of present economic restraint, and the burgeoning increase of health care costs in Canada (Lalonde, 1974), possibly the elderly can be maintained by less costly means (other than in institutions) through provisions such as day care and day hospitals, etc. As well, institutions may do well to foster independence and social interaction in the facility environment.

Related studies, such as O'Donnell et al. (1978:267), have recently presented a methodological approach for assessing the subjective perceptions of nursing-home living by the nursing-home residents themselves. O'Donnell and his associates feel that psychosocial perception assessment can tap into important aspects of "quality of care" often missed by staff-resident ratios, cost per patient data, and patient chart review approaches to nursing-home evaluation surveys (p. 270).

The above researchers and many others have attempted to rationally examine the psychosocial environment and its effect on the elderly resident since the time Goffman first initiated his concept of the total institution.
In summary, research thus far underscores the complexities of the relationship among a host of variables in a variety of long-term care facilities (the quality and components of care, physical environment, size, resident and staff attitudes, source of reimbursement, administrative policies, relationship to community, and so forth). However, there are a number of general factors which have been identified that affect a positive outcome for those experiencing institutional transitions. Most importantly, the positive factors identified from research may provide the basis for future practice and policy directions to assist us in providing a more optimal environment for our elderly population.

1. Positive Institutional Factors

In a study conducted by Lieberman (1969), the negative effects the elderly experience when entering institutions were attributed to the degree of change between the receiving and original environment. Of particular importance was the strong association of outcome status of the patient with the psycho-social "milieu" or quality of the receiving environment. The study also indicated "that patients placed in cold, dehumanized, dependency-fostering environments show declines" and emphasized the importance of the institution permitting continuity of previous lifestyle (Lieberman, 1969:330). It is possible that current trends aimed at "deinstitutionalizing" institutions, for example, making them more open and accessible
to the outside community, less congregate, and so forth, are effective because they prevent the use of prior and less adaptive responses (Tobin and Lieberman, 1976:22).

A study by Marlowe (1972) found that two comparable groups, who moved, experienced opposite outcomes: one group adjusted successfully, the other did not. The results of the study suggested that the improved group went to environments that encouraged resident control and independence in their lives, offered privacy and respect, fostered community access and integration, promoted social interaction and self-disclosure, and treated residents with warmth and positive attitudes. Under opposite conditions, the other group deteriorated.

Other evidence also supports the contention that the institutional environment has an impact on the adjustment and life satisfaction of the elderly. Factors of importance suggested by researchers include: improved visiting patterns and reassessment by attending physicians, a positive perception of the facility and staff, self-rated health, a more favourable disposition toward entry, and a view of the residence as permanent (Gutman and Herbert, 1976; Noelker and Harel, 1978).

Practitioners and researchers have also provided practical and constructive measures that have beneficial results: "preparation of the mover via individual and group counselling,"
orientation to the new facility such as pre-move visits, participation of the potential mover in the decision-making process, opportunities for choice and continuity of the staff” (Liebowitz, 1974:294). In fact, Liebowitz (1974), a well-known researcher, goes so far as to state "that a review of the literature suggests that lack of attention to the psycho-social, human needs of the elderly can be lethal" (p. 294).

The relocation period lends itself to the implementation of innovative and imaginative techniques to lessen the stress of relocation and generally improve the quality of care. For example, assessment, diagnostic and treatment techniques may help to assist in the appropriate placement, orientation, and treatment plan for individuals (particularly the psycho-geriatric resident and the brain-damaged). As well, positive attitudes of the administrator and institutional staff, the encouragement of social responsibility, interaction with other residents, and significant others, can also contribute to one’s feeling of belonging and self-worth. It has also been shown that the elderly benefit from a highly individualized treatment plan, tailored to their unique life experiences, personalities, and needs (Brody, 1977:274). At the same time, however, adequate integration of the individual and institution is still in the nascent stages of our knowledge, thus proffering potential challenges for those working in the community and institutional settings.
The preceding discussion has attempted to cover a wide range of current research and some theoretical concepts relevant to understanding the effect relocation has on the elderly. Relocation stress literature has demonstrated that relocation affects psychological, biological, and even physiological processes.

Although a great deal of past research findings has often been questioned and criticized on the basis of the study design and methods used, more recent and sophisticated research methodology strongly indicates an association or linkage between the experience of relocation and the noted deleterious effects. Current research no longer disputes the fact that relocation is a hazard for those elderly relocating to institutional settings. As Bourestom and Pastalan (1981) suggest, current research is now attempting to determine what characteristics of the population and under what conditions are the negative or positive effects observed.

Of major importance is the search for more effective strategies for alleviating the negative consequences of relocation (Bourestom and Pastalan, 1981). At the present time, some important clues have been found that may be beneficial in influencing and improving better strategies and interventions of helping the elderly adapt to relocation.
Given that relocation is a major stress that radically affects many elderly and can be a predictor of death, the fact remains that although we have some ideas about how to minimize the risk, we still have little knowledge of how to facilitate the well-being of the elderly. Despite the wide variations of the samples studied and the conditions under which individuals were relocated, the empirical findings suggest that the percentage of elderly, showing decline after relocation, is still significant.

As well as helping the individual through the transition process of pre- and post-relocation, a broader outlook is demanded. That is, we must concern ourselves with helping each individual to express those aspects of self that yielded satisfaction in independent living.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

During the past several years, social workers are assuming an increasing role in the delivery of health, social and mental health services to the aged. In the future, it can be predicted that their function will increase and become more diversified. Although difficult, it is imperative that health professionals understand not only the significance and complexity of the relocation process, but also utilize and develop further innovative strategies to help minimize the risk of relocation.

The process of relocation is important for a number of reasons. First of all, relocation frequently signifies a
relinquishment of independent living. As well, social relationships and a former pattern of living are disrupted. The disruption and stress involved often requires considerable adaptation and adjustment on the part of the individual. Furthermore, a decision to enter a home and actual entry has usually been preceded by a series of precipitating events which may overwhelm or overtax the individual and his/her family. Most importantly, the conditions and procedures regarding how the move transpires can have lasting or residual effects for the individual in the receiving institutional setting. Consequently, it is crucial that the process of relocation is sensitively and carefully managed.

In the following section, the stages of relocation will be outlined with implications for social work practice. Hopefully, the material presented may be helpful to social workers and other health workers who are interested in promoting the well-being of the elderly relocating.

To help clarify the variety and complex sequence of emotional responses and experiences characteristic of the relocation process and the demands that face the older person, the process will be arbitrarily divided into a framework of four stages: (1) the decision and preparation: encompassing the period of time that relocation is being considered to the time that the prospective resident is notified that a facility bed is available; (2) separation:
refers to the time that the actual notification is given until the point of admission or impact; (3) transition; refers to the first day in the facility; (4) incorporation and settling-in; refers to the days after actual admission and continues until the resident views the facility as a permanent home (Pope, 1978; Tobin and Liberman, 1976).

A. Characteristics and Precipitating Factors

Before turning to practice issues that may help mitigate relocation stress, it is important to have some knowledge of the research studies which have examined the reasons or precipitating factors that have been associated with the elderly seeking and entering institutional care.

Researchers have found that the period prior to moving is particularly stressful as the older person anticipates relocation to an unfamiliar environment (Zweig and Csank, 1976; Tobin and Lieberman, 1976). During this period, the individual must make the crucial decision as to whether a move is required, find a suitable institutional setting, deal with entry procedures, and contemplate disposing of his possessions.

Considering that institutional moves are invariably anticipated with considerable anxiety and fear along with a sense of separation, loss and rejection (Lieberman, 1976), why do older people move at all? Furthermore, who enters long-term care facilities?
Although precise data is difficult to obtain about the institutionalized elderly for a number of statistical reasons, generally those who apply are the very old, impaired mentally and physically, are predominantly white, with few representatives from racial or ethnic minorities (Brody, 1977:90). In his United Kingdom survey of institutions, Townsend (1962) found that far more women than men, the single, those who never had children, or those who lacked social supports, were characteristic of the elderly who entered institutional care.

The proportionately high rate of the institutionalized old is also characteristic of Canada's population. In Ontario, for example, over one-third of the population over 85 years of age were in some kind of institutional setting on any given day in 1976 (Schwenger and Gross, 1980:252). For those over age 75 in Canada, 15 percent are estimated to be living in institutions (Special Committee, 1966:107).

The chances of applying and becoming a resident increases progressively with advancing age (Brody, 1977; Brotman, 1968). Accordingly, the very old are vulnerable to multiple assaults of aging, i.e., mental, physical and environmental. It is interesting to note that many people with similar characteristics are not necessarily in institutions but remain in the community. Shanas and associates (1968) have identified that between 9 to 14 percent of old
people living at home are bedfast while approximately 15 to 25 percent of elderly community residents appear to suffer from some degree of mental impairment or illness. Thus, there is reasonable evidence that the degree of mental or physical impairment are not the predominant reasons for the admission of a large number of old people to institutions.

Certainly, reasons for moving vary with the type of move or transition being considered. In the cases of inter-institutional and intra-institutional moves, elderly individuals may be subjected to a transfer, often beyond their control. For those elderly already in institutions, they often have no one to care for them after discharge, or their medical/emotional condition warrants the kind of skilled nursing and supervisory care that can more easily be dealt with in another institution.

These elderly may also share similar reasons for moving as those elderly moving from the community to an institution. Studies focusing on identifying reasons for community elderly applying to institutional settings have identified a multiplicity of reasons or precipitating factors, besides a need for medical or nursing care (Brody, 1969; Tobin and Lieberman, 1976). Briefly, additional reasons identified are as follows: social isolation engendered by a lack of, or adverse change in close and supportive relationships with significant others (Barney, 1977; Beaver, 1979; Tobin and Lieberman, 1976);
inadequate housing or neighbourhood deterioration (Beaver, 1979); economic difficulties (Harris, 1968; Townsend, 1962); anticipated inability for self-care (Gutman, 1978; Kraus et al., 1976 b); and a lack of community based resources to provide assistance at home (Brody, 1966; Kraus et al., 1976 b).

Additional support for these findings was also reported in a recent Vancouver survey conducted by two Master of Social Work students. Based on a small sample of residents recently admitted to a local Vancouver intermediate care facility, "we found that the primary reasons given by residents for entering care were: declining health, lack of social supports, and dissatisfaction with neighbourhood and/or location. Of the sample population studied, 50 percent also gave additional reasons including most of the above" (Hanvey and McLachlan, 1981).

In general, poor health and/or emotional problems, often in combination with a deficiency of economic, social, personal and community resources, may culminate in a decision to apply for facility care or a transfer to a more appropriate medical setting.

Literature Regarding Decision-Making

In view of the fact that the decision-making process, including reasons for the move, anticipation, planning, preparation and emotional reactions to the move, is crucial to
relocation outcome (Beaver, 1979), there is a paucity of literature or studies, particularly Canadian, which have focused on the relocation process per se. Canadian research of the relocation process is necessary to determine possible fragmentation or gaps in the existing services which may impede the transition of relocation on a provincial and local level.

With this in mind, a Vancouver survey (previously cited) was undertaken to determine not only the most influential factors that led the local residents to seek institutional care, but also to determine if older persons consulted with others prior to deciding to move or arrived at the decision independently. Since the voluntary/involuntary nature of the move has also shown to be an important predictor of the outcome, the study also examined whether the institutional residents felt "pressured" to move by others.

In the study, only 30 percent made the decision on their own, while 70 percent consulted with others. Physicians and medical social workers were more likely to play an important role in the decision to apply for institutional care than either family members or other relatives.

Considering the number (20 percent) who were hospitalized immediately prior to institutionalization, these findings are not surprising. No doubt, hospitalization and the change in medical, social and psychological status,
as well as contact with medical personnel, led to their subsequent placement in a long-term care facility.

Of concern was the finding that 40 percent reported they felt "pressed" to move by either physicians, hospital social workers and, to a lesser extent, family members. Several subjects mentioned a lack of alternatives precipitated a move to a care facility. This finding led us to conclude that perhaps professionals (and families) need further education regarding the availability of community services and greater expertise regarding preparation of the frail elderly.

B. Practice Issues in Decision-Making

What practical aspects or interventions can assist the elderly during the decision-making and preparation phase of relocation?

First of all, it is important for the assessor or social worker to explore with the elderly their motivations for considering institutional care. Is institutional care the only available alternative? In view of the fact that sometimes pressure is placed on the individual to seek institutional care, underlying incentives and an understanding of individual and family dynamics should be thoroughly and sensitively explored. If, for example, the family is not included at an early stage, members may sabotage or interfere with the carrying out of future planning. Often, a decision
for application is considered during times of emotional crisis, when the individual and/or family feel cornered or trapped into viewing facility care as the only definitive solution. At these times, people may not be in a position to adequately explore or evaluate more appropriate alternatives.

In my opinion and from experience of working with the elderly, it is often useful and beneficial to counsel or interview individuals in their natural surroundings, not only because of physical and mental incapacity, but also to ensure that they feel comfortable and more at ease. While the elderly play the role of host, they often provide insight into who they are, their values, norms, history and filial bondings by referring to family photographs, sharing colorful anecdotes and reminiscing about their lives. Since the individual is often under a considerable degree of stress, or feeling vulnerable, it is also more productive to initially interview the elderly alone, thereby freeing self-expression without the fear of sanctions or defensive stances from concerned and interested family members. As well, individual visits help to convey and confirm that the prospective resident's opinions and concerns are important, valued, and that their participation is essential. After all, crucial and final life decisions are essentially theirs.
Sensitive issues regarding whether they had anticipated spending their final years in an institution; whether they feel abandoned, rejected or angry toward significant others; the quality and frequency of help received in the present and past; whether they had previously anticipated eventual institution; and whether they believe placement to be the ultimate separation, ending in death or another beginning, help to clarify or identify areas that may merit further exploration and testing within the family group or on an individual basis.

1. The Importance of Seeing the Family Together

Family members should be encouraged to attend family sessions, thus providing the social worker or the health worker with the opportunity of viewing each family member within the context of the family network. Seeing the family conjointly may assist the social worker in identifying faulty communication patterns or dysfunctional interactions. As well, family systems work supports the contention that at times of emotional crisis or disruption, family members are more open to intervention, and with professional assistance may be able to mobilize their resources and energies to effect positive changes (Haley, 1977:126). A premise of family therapy for bringing the family together also rests with the assumption that change in one part of the system affects the rest of the system (Freeman, 1981:21).
In instances where a decision is being made to separate a member of one generation by placement in an institution, this process can have repercussions or effects within and among other generations. As well, it has been demonstrated that a disruptive family member can become part of the scapegoat process or, as Brody states, "the older person can become the focus and storm center of irrational feelings" (Brody and Spark, 1966:78). With increasing age and accompanying dependency, the aged person's family may not be able to deal with the demands and escalation of stress incurred by the elder member's situation. The role of the social worker is to help identify internal and external resources within the family and community, as well as assist the family to devise its own strategies and solutions to restore the family's equilibrium (Freeman, 1981:24).

A Case Illustration

The following illustration of a three-generation family demonstrates the disruption, stress and ensuing guilt that may accompany anticipation of an elder member separating from the family. Most importantly, it will serve to illustrate and emphasize the emotional and behavioural processes that occur throughout the generations.

On behalf of her elderly mother, Mrs. N. made application for admission to a local multi-level care facility.
After a period of several months, a facility bed became available. Two interviews were arranged in the home of Mrs. N. which produced the following impressions.

For the past eight years, Mrs. L., an 86-year old woman, had lived in her daughter's (Mrs. N.'s) home along with her son-in-law and their two teenage children, a boy and a girl. Of concern to the social worker was the knowledge that the daughter had avoided discussion with her mother regarding the pending move, giving such reasons as "she would not be able to understand and, even if she did, she would resist placement." Mrs. N. was obviously concerned and fearful about her mother's reactions to placement and needed help in this area. As a result of the social worker's suggestion, Mrs. N. was encouraged to rehearse beforehand how she would inform her mother about the possibility of placement and how she would introduce and explain the arrival and function of the social worker.

Mrs. N. had placed her mother on the facility waiting list at the time her mother had become incontinent. However, now that placement was imminent, she was having difficulties following through with the plan and was reconsidering her decision. She admitted that she felt enormous guilt and had difficulty accepting the idea that her mother would likely be placed with other confused, debilitated and sick people in an old-age institution.
While Mrs. N. had several sisters and a brother, she had borne the burden as a primary care giver. For a recent one-week period, the mother was sent to another relative's home to give the family some relief. This was the only time the elderly woman had been absent from the home in many years.

Mrs. N.'s mother had limited sight and walking abilities, compounded by periodic incontinence. Although often delightful, she experienced periods of confusion, forgetfulness and eccentric behaviour. Having strong likes and dislikes, she threw food on the floor or cagily crumpled it into a ball and slipped it on to the floor. In addition to meal times, tasks of bathing and changing her clothes often erupted into a family battlefield. Suspicious and mistrustful of others, she believed the family was trying to steal from her. Usually, she clutched a large "security blanket" which she would not easily part with, and only if accompanied by her daughter would she venture out-of-doors.

In this illustration, the daughter assumed the role of "burden bearer" (Brody, 1966), while the only son, who remained on the periphery of the family, was seen by the elder as one of her favourites. The favoured position of the son or specific family members is not uncharacteristic of inter-generational families. Frequently, relatives who live some distance away, or who have minimal involvement in the actual care demands, may not understand the full
implications of what it means to care for a dependent parent on a daily basis. Often, visits are conducted during the most optimal, favourable and pleasant conditions which may not reflect the more unpleasant aspects of the situation. Relatives who have minimal responsibility may be more tolerant, shower attention and affection on their elderly parent(s). Similarly, relatives may experience pangs of guilt due to their inaccessibility and may question or challenge the caretaker's actions or decisions. Certainly, complex factors may lead to friction, misunderstanding, hostility, and blame among the family.

In order to identify areas for intervention, the worker must be alert and sensitive to the underlying currents and interactions within and among the network of multi-generational families. In my opinion, the health worker must take a holistic view of the family rather than primarily focusing on the identified problem.

In the illustration, the granddaughter resented her grandmother's increasing dependence and limited functioning since she had to assume responsibility in the form of "baby-sitting" services. The son-in-law and grandson were relieved from responsibility for care or modification of the grandmother's behaviour in the family. In this instance, the grandmother's condition and behaviour seemed to fragment and polarize family relationships. The social worker helped the daughter to openly and honestly discuss with her mother
the issues around placement. Although it was a painful and emotional experience for the daughter and the mother, the discussion helped clarify and provide a basis for eventual separation. In contrast, a lack of open communication may later have proved disastrous, or have led to serious adjustment problems throughout the relocation process.

As a preventative measure, the worker facilitated the expression of feelings, helped the family obtain appropriate information about community services and facility life. The worker also helped them (particularly the daughter) to identify their part in the process of maintaining the status quo.

Most importantly, the worker focused on maintaining their self-esteem, relieving their guilt and anxiety, as well as exploring the meaning and change in family structure that would result from the grandmother's removal from the home. How would they spend their time, devote their extra energies and relate to each other once the centre of their attention and routine was missing? As well as feeling enormous guilt, devotion and responsibility, Mrs. N. had to consider her own aging and future. With her teenage daughter's hostile, angry and resentful attitude in caring for an aging member, how would the daughter respond to Mrs. N. in later years? All of these issues and a vast array of others are themes that are often interwoven into the earlier stages of the relocation process.
Although Mrs. N. decided to deter placement for the time being, the family was encouraged to visit the facility with the elder and participate in social events, and to continue contact with the worker if they wished. In this way, all would, hopefully, be able to adjust to the idea of placement and become more familiar with institutional life.

2. Family and Community Supports

The case illustration is also indicative of the considerable caretaking role that family members assume and how the provision of such support can delay or prevent institutionalization for an elderly member manifesting significant infirmities. Research studies have also shown that persons living with their children or significant others are more infirm on admission than those elderly living alone in the community (Townsend, 1965).

The enormous and extensive help that relatives supply to people at risk in the community is well-documented (Townsend, 1965). For example, a Canadian survey of an institutionalized population (Kraus et al., 1976 a) reported that more than half of their sample were receiving assistance from the family prior to admission; had been moved to the family home, or were receiving total or extensive help. As in the example cited, the offspring often devote equivalent or additional time as that required in full-time and paid employment.
A survey, conducted in Vancouver (Hanvey and McLachlan, 1981) of a small sample of intermediate care residents, reported that 55 percent of the sample who had close relatives received help either on a daily basis (45 percent) or received this help on a weekly basis (10 percent) prior to coming into care. Of these subjects, 45 percent had actually lived with a spouse, or son or daughter, who assumed the responsibility of providing the daily assistance. Accordingly, the burden and stress incurred from looking after an aging parent is one of the more significant reasons found for relatives making or considering application to an institutional facility on behalf of their parents (Kraus, 1976 b).

It appears that if the elderly require instrumental assistance they first approach their families, then their friends or neighbours, and lastly, bureaucratic substitutes for families (Shanas, 1979). Furthermore, there is a reciprocal or mutual expectation from both aging parents and offspring that the elderly have a "right" to filial services (Sussman, 1976).

In the Vancouver study of intermediate care residents (Hanvey and McLachlan, 1981), it was found that although 80 percent of the residents had friends, only 35 percent had received help from these friends. The assistance received from friends in contrast to that received from relatives was of a lesser degree and/or quantity and of a different nature (i.e., transportation, shopping/banking,
yard maintenance and surveillance). The survey concluded that the reasons for some not receiving assistance from friends may have been partially attributable to the possible declining health and frailty of the friends, or may reflect a tendency to view emotional support given by friends to be more important than help with tasks, thus accounting for the low reporting of services provided. However, this hypothesis would have to be validated by further research and study.

As represented by 45 percent of the sample, the absence of an informal family support system would indicate that while these subjects lived in the community prior to institutionalization they would have required comprehensive care from community agencies. For those subjects having family support, further community support might have helped to supplement their current care needs as well as provided some relief to family members. In the same sample, it was found that 60 percent had regularly utilized homemaker services while 35 percent had utilized meals-on-wheels.

Although it was gratifying to note that the utilization of homemaker services and meals-on-wheels was high in comparison to other Canadian samples of community elderly, it was of some concern to learn that other existing services were either under-utilized or not used at all. For example, services such as home nursing, transportation, friendly visitors, phone-service, day-care services, and so forth,
were barely represented — possibly reflecting the considerable degree of support that family and, to a lesser extent, friends had provided.

It is unfortunate that services such as day-care were not used since these services can often help to provide an effective interim or alternative service to placement in an institution. If we are genuinely concerned about preventing undue stress and disruption in relocating the elderly, the availability, accessibility and suitability of existing services must be thoroughly explored and examined. As well, these services must be made known to those in most need of such resources.

C. Research as a Basis for Practice

The above discussion indicates the pattern of support and care that is utilized by community elderly. It seems that family ties and bonding remain strong, that family care and support, if available, are preferred in comparison to alternative support services. Only when the demands exceed or overtax the family's ability to cope, or when all resources have been exhausted, do families consider application to an institution as exemplified by the preceding illustration.

Considering the importance that the family holds for the elderly, and in view of the onerous responsibility often assumed by family members, it is crucial that not only the
individual at risk, but also family members should be involved at an early stage in the decision and preparation stage.

In my opinion and as the studies indicate, other transitions should also include and involve family members, if possible. Although other moves, such as a transfer of residents from one institution to another, to another ward or even a room change, may prove less traumatic, still these transitions should be thoroughly discussed and include participation by the individual and available family. Studies indicate that the family may play an important role in alleviating relocation stress.

Since many Canadian citizens have immigrated to Canada from other countries, often reflecting different cultures, customs, religions and languages, it is important for the social worker to be aware of the heterogeneity and uniqueness of the elderly population. In 1976, for example, 8.7 percent of all immigrants to Canada were over the age of 65 (Immigration Statistics, 1961-1977). The decision to enter an institution for multicultural aging populations may hold different meanings, connotations, and anticipations for these elderly. In the Jewish culture, for example, being placed into an old-age institution, or moshave zakenim, is equated with being sent to the unpleasant European poorhouses for the aged and indigent. Differences may preclude the attainment of entitled services because of language barriers and social
and cultural isolation, to name but a few.

In view of these differences, the social worker should ensure that elderly cultural groups are aware of the available services and realistically understand the implications of services offered. In the previous case illustration, the elder woman spoke faulty English as a second language. It was imperative that the important information regarding placement plans were relayed to her by the daughter using her native language. Particularly for confused, forgetful elderly who may not have a good command of the English language, one cannot assume that receipt of information will be accurately assimilated or interpreted.

D. Assessment and Preparation

Once the decision has been made, the aged individual must make application. In British Columbia, a professional consultant or assessor receives the referral from a multitude of possible sources (the individual, family, friends, physicians, community agency personnel, and so forth). An appointment is usually scheduled to meet with a local long-term care assessor to determine whether the person would benefit from institutional care, considering his/her care level and the individual's personal situation. In most cases, a long-term care assessment form with the individual's demographic information, medical diagnosis, prescribed medication, psychological and functional ability, the name of a sponsor, if available, and two facility selections, must be gathered by
the assessor. In my opinion, care should be taken to preserve the individual's rights, dignity and self-respect when the elderly person is initially being assessed. Empathy, sensitivity and active listening are a few of the skills required. For many elderly, the symbolic significance of signing their name on the assessment form, thereby mobilizing the bureaucratic system and process for institutional placement, is in itself stressful and anxiety producing.

Preferably, when application is made, the individual's family or concerned others should have visited a number of care facilities to ensure that a suitable or appropriate placement is eventually realized. Moreover, the applicant will, hopefully, have accurate and realistic knowledge concerning specific facilities upon which he/she can base his/her choice. Ideally, it should be feasible for the elderly to spend a weekend or an overnight visit (or an appropriate period of time) in a facility of their choice to gradually prepare for institutional life if they so desire. Well in advance of actual placement it is hoped that the assessor would be able to determine which of the applicant's selections will have the earliest vacancy. This information could then be relayed to the individual and family.

Obviously, some individuals may require a greater degree of preparation than others. Flexibility within the system should preferably accommodate individualized planning. Pre-placement visits and tailor-made planning for relocating
children and adolescents is an integral component of good child welfare practice. Personally, I believe such practices should be included in our methods for relocating the elderly.

If possible, cost factors, the physical and social milieu, the size and choice of rooms, whether they can bring their own furniture, an understanding of their rights and other specifics regarding individual facility selections should be considered and discussed.

As indicated in the literature, an honest appraisal of the person's situation, the reasons or basis for recommending institutional placement, the encouragement and voluntary participation of the individual, are important and crucial aspects of the preparatory stages of relocation. In general, the assessor should ensure that during the application phase, the individual's rights and vulnerabilities are protected.

Waiting and Preparing for a Move

Once the decision and application has been made, the individual must now wait and anticipate institutional placement. As well, personal and legal affairs must be put in order, arrangements made for the disposition of many of life's possessions including family pets and property, and a shift in mental set or attitude is required to prepare for relinquishing the former lifestyle. At the same time, however, a few community elderly may experience a series of precipitating events which may demand immediate entrance to
a facility on an emergency basis. Thus, neither the individual, family or health care workers are able to adequately prepare for relocation during a serious crisis.

The progression of events leading to institutional care is invariably not easy or effortless, particularly when one considers that often the resources of the elderly at this stage may be at their lowest ebb. Moreover, Tobin and Lieberman (1976), in their studies of community elderly awaiting placement, have noted that feelings of separation, rejection, abandonment, and thoughts of death are often evidenced in the waiting list population (p. 99). The sense of abandonment or separation may be understandable when we note that often the loss or lack of supportive relatives, or the incapacity of the relatives to provide care, distinguishes those people who live in the community from those who must seek institutional care (Tobin and Lieberman, 1976:109).

For those on the waiting list, what effect does waiting have on the ill and debilitated older people who require institutional care immediately but must endure severe stress in precarious situations and/or possibly dangerous environments? What are the effects on the families?

The waiting period lends itself to providing interim services and supports as well as indicating a need for social work interventions to help the individual (and family) cope with the emotional and stress-provoking
experience. During the interim period, there may be a crucial need for the assistance of a social worker to mobilize community services and family supports.

E. Separation

Once Long-Term Care notifies the prospective resident of a vacancy, sufficient time should be allocated to pack personal belongings, say good-bye to friends, and make suitable arrangements for admission. As it exists now in British Columbia, Long-Term Care can give little notice of a facility vacancy (usually only one to a few days prior notice) and can provide minimal or, in some cases, no assistance to help individuals deal with the actual physical tasks of moving.

A lack of instrumental assistance is particularly evident when the elderly lack available social support. For example, an elderly gentleman in a local hospital was notified of an available bed and rushed to the facility the same day. His only relative, a niece, lived on the east coast and was unavailable to help perform and organize the instrumental task of moving his furniture and belongings from his previous hotel residence. For over a week, this mentally alert and pleasant fellow was without a change of clothing and other personal effects. Needless to say, this caused him considerable distress, anger and hostility. He reacted by refusing to budge and held a "sit-in" in the facility's lobby. It was beyond his and the facility staff's
comprehension that there was a lack of professionals, paraprofessionals, and/or volunteers available to meet his vociferous demands. This example illustrates how not to relocate an individual. One can speculate about how this horrendous experience affected his subsequent adjustment and the residents’ and institutional staffs’ initial impression and attitudes towards him.

F. The Transition

In order to avoid the development of unfortunate situations like the one previously cited, Long-Term Care should, if possible, forewarn individuals at least one week in advance. Adequate notice could assist the liaison worker in arranging for a smooth and organized transfer from the community to institution, between facilities, or within an institution. For the elderly, it is particularly important that the move is handled in an unhurried, uncomplicated and patient manner since they may not be as resilient to disruption and change as younger individuals. A reasonable length of notice given before the move transpires can also ensure that adequate and suitable arrangements are being made in the receiving environment. Community and institutional staff must coordinate their efforts to provide a welcoming and comforting atmosphere at the point of entry or impact of admission.

Crossing the facility threshold is a deeply emotional and stirring experience not only for the individual, but
for the family and concerned others. With few exceptions, tears accompany admission. At the point of entry, an inner hope or faith seems to persist in the mind of the older person that somehow he/she will miraculously be saved from the fate of institutionalization. When family members or friends do not offer or invite the relocatee to live with them, or when alternate solutions do not materialize, the reality of their situation is often "accepted" with a variety of attitudes and emotions. These emotions may set the tone for adjustment in the new life.

The family also may be experiencing mixed emotions at this time. The series of events leading to actual admission may have caused considerable stress and anxiety while waiting for placement. As well as a sense of relief or a freedom from responsibility, family members may also experience mixed feelings of guilt, resentment and anger, love and affection. Thoughts and concerns about whether they made the correct decision, whether the newcomer will "fit in" with other residents, make friends, find their way around, and receive some satisfaction and happiness in the new environment are very real issues in the minds of family members and the new arrival.

Throughout the stages of relocation, emotional support and encouragement should be given by the social worker and residential staff to assure both families and the newcomer that they have made the best decision possible under the
circumstances. Of importance also is the social worker's role of instilling in the relocatee the sense of connection or continuity between his past and present life. The idea must be conveyed that satisfying aspects, interests, personal and social relationships of independent living may continue and may possibly be enriched in the new environment. A sense of hope, optimism, confidence and reaffirmation of purpose for the future (and tempered with realism) should be encouraged or promoted. Respectful attitudes, reminders of past accomplishments and assets will help to realize these objectives.

An appropriate or typical "first day" might include the following considerations. During the first day preferably, the social worker should meet and greet the new arrival (and family) at the door. Introductions should be made to key staff, and particularly, to reacquaint them with residents they may have known in the past. The trauma of admission may be as much as the frail newcomer can deal with for one day, so it is important not to overexpose or overtax the individual.

If possible, family or a staff member should be encouraged to stay for most of the day to help unpack belongings, decorate the room and generally help the newcomer get settled. It is preferable to have a family member join the relocatee for meals or tea to assure the individual that family ties will be maintained or continued.
In addition, the presence of a "concerned other" contributes to feelings of comfort, security and a sense that he/she is still loved and cherished.

Since the frail elderly are vulnerable to abuses of their rights and dignity and do not, as a rule, fight for these rights, it is crucial that a resident handbook or specific information outlining the rules, procedures and appeal mechanisms of the home is given to the residents and family. Constraints of the institution, formal policies, written rules and procedures, tradition, professional and sub-professional roles and investments, patterned ways of looking and dealing with the elderly, administrative and business operations — all may affect and hamper intentions to safeguard the rights and dignity of the elderly and their subsequent adjustment to facility life. Often, families can act as advocates to ensure that their elderly relatives' rights are not abrogated. If relatives have some knowledge of the facility's and Long-Term Care's regulations, administrative structure and mandates, they can also help interpret existing rules in an acceptable manner.

1. Hospital

Although transitions described often involve a move from the community, transitions from other institutional environments and situations frequently occur. For example, studies demonstrate that placement from hospitals is not an uncommon occurrence. In a study of institutionalized
populations, York and Calsyn (1977) reported that 59 percent and 55 percent of two samples had come directly from hospital. In a Vancouver survey of intermediate care residents (Hanvey and McLachlan, 1981), 20 percent of the sample were in hospital immediately prior to institutionalization.

In acute care hospital settings, management committees have concerned themselves with accounts of in-patient costs in order to free up beds and send the elderly out at the first opportunity. Attitudes of hospital staff and physicians, lack of knowledge of each facility, and transfers of patients with insufficient information also contribute to slow transfers, disruption, and stress. As a result, there is a need to improve and coordinate transfers between long-term care facilities and acute care hospitals.

A Multi-Discipline Approach

In instances where the prospective resident is awaiting placement in an acute care bed, the facility social worker or the long-term care assessor and the patient should (if possible) be given several several days notice by "central registry" that a facility bed is vacant or will soon be available. Prior to discharge, either the facility worker or local assessor should arrange to meet with the hospital social worker and resident to first determine if the individual is, in fact, ready for discharge, and that the chosen facility is able to meet the patient's care needs. Coordination of transfers could include a team meeting of hospital, medical
and nursing staff, local assessor (and the patient). A team approach would be useful in identifying possible medical, physical or social difficulties that are pertinent and crucial to the effective transfer arrangements and the subsequent adjustment of the individual after discharge.

A multi-discipline and unified approach to after care might help alleviate possible confusion and misconceptions that the patient or the various disciplines and their respective agencies may have regarding the transfer and discharge plans. Similarly, arrangements for physiotherapy, outpatient care, prescriptions, medical care plans, the mode of transfer for the individual and his/her personal effects, and contact with the patient's family or friends are some of the major issues that require attention well in advance of actual placement.

Within the constraints of the current health care system, the facility social worker or the long-term care consultant could act as a liaison and ensure that he/she is informed of a change in plans or in the condition of the patient. The hospital social worker, on the other hand, could accept the responsibility of closely monitoring the patient's condition and plans in order to accurately relay relevant information to the liaison worker. Not to be forgotten, facility providers have a need to know of plans for discharge so they, too, can help facilitate a smooth and organized move.
2. Intra/Inter Institutional Transfers

Within the present Long-Term Care system, a change in an individual's care level can also result in a transfer to another floor or, more likely, to another facility. An individual settled in a facility may find himself forced to move to a facility where his needs can be met. Again, moving to either another facility or within the facility can be disrupting and stressful for not only the individual, but also concerned family members. Again, a coordinated team approach between facilities or wards might prove beneficial. The facility staff or assessor (if a social worker is not available) should adequately prepare the individual and family for the pending move. Packing, moving and readjusting may not be easier the second time in view of the likelihood that the individual has experienced an increasing loss of health and functioning. Casework services and professional counseling may be needed to help the individual and relatives get through this difficult time.

G. The Stage of Impact and Incorporation

The final phase, the stage of impact or incorporation, refers to the period of time after the first day of admission and until the new resident views the new facility as "home" (Pope, 1978).

Several studies indicate increased mortality both immediately before and after relocation (Costello and Tanaka,
1961; Epstein et al., 1971). Furthermore, during this period, the most adverse psychological effects of relocation are evidenced (Tobin and Lieberman, 1976). Coleman (1973), for example, has shown that stress may be characterized by such forms as hyperirritability, sleep disturbances, disrupted relationships, and ego-defense oriented reactions including emotional insulation and detachment.

The work of Bowlby (1969) and his study of children's reactions to separation experiences as a result of hospitalization also revealed similar effects. Brearley (1977) reports the distress and distortion of relationships that accompany admissions to hospital and homes for the aged, as well as increased susceptibility to infections and hospital related illness. Further evidence by Pope (1978), in a review of residents newly admitted to old people's homes as emergency admissions, found that a quarter were depressed or confused on admission, 6.1 percent resigned to their fate, and a further 12.2 percent died within the first three months. Tobin and Lieberman (1976) also found that mortality rates particularly increased during the first three months after relocation. Townsend (1962) suggests more specifically that the chief changes in an individual's psychology and behaviour occur during the first days or weeks after admission to an institution. He comments: "The individual seems to receive a lethal shock which causes him to adapt quickly to a new level of behavior and to adopt certain new attributes toward
his environment and himself" (p. 367).

Of particular interest is also a study by Zweig and Csank (1975) of a mass transfer of geriatric war veterans of St. Anne's Hospital near Montreal to a new medical building. These researchers found that the months that immediately follow relocation is not necessarily the crucial period. Although patients were involved in a stress-prevention program, "there was a latency period of some months' duration after which the major post-relocation impact of the move was felt" near the end of five months of residence (p. 275). It may be that not only immediately prior and after relocation, but several months following the move is also a critical period resulting in an increase in mortality rates.

Practice Implications

With respect to the above research, actual entry to the institution and several months following is a particularly vulnerable and climacteric period for the new resident and existing relatives. What kinds of interventions and strategies can be utilized by the professional social worker, consultant or residential staff to help prevent or alleviate adverse relocation effects? More importantly, how can we help the individual (and significant others) adjust or adapt to relocation and institutional life?
Experience in working with elderly indicates that some practical considerations and direction are necessary to help the individual "settle in" and prepare for his/her new life. Obviously, time should be taken to gradually familiarize the individual with the schedule, routines, key staff, residents, residential services, physical environment, and so forth. Since the first days in the facility may seem overwhelming, confusing and hectic for the individual, it is important that staff and other contacts have a great deal of patience, empathy, consideration and positive regard for the newcomer.

The individual's situation could be compared to what most of us have experienced at one time: being the new kid in school or a foreigner in a strange country. Although these analogies are oversimplified, they serve the purpose of alerting care staff to some of the feelings and difficulties the individual may be experiencing on a more personal level. It is important that everyday procedures or routines, often taken for granted by residential staff, are discussed and clarified for the resident's benefit. For example, forewarning the new resident that a nurse may enter their room to perform a customary bed check at night, or that their room-mate is a fretful and noisy sleeper, or that a staff member will knock on their door to awaken him/her at a certain hour are courtesies that should be extended to the resident. In this way, possible concerns, fears and anxieties that may escalate in a strange and unfamiliar environment could be alleviated.
Washing, bathing, and toileting are everyday events which we also take for granted, and yet, facility staff may as a matter of course perform or regulate these functions. Residential staff may inadvertently infringe on the resident's personal dignity or privacy within the constraints or regime of the institutional setting. Although not to belabour a point, considerations of basics such as these can influence a person's sense of self-worth and his/her desire to belong.

Coping and Adaptation

In working with relocated elderly, feelings of loss, hostility, separation, helplessness and hopelessness are often noted. These characteristics are often accompanied by reminiscences; a longing for a former environment and lifestyle; regrets or mourning regarding decreased mental and/or physical health. Increased regression and/or the use of defenses such as denial are often observed. However, these factors should not constitute the sole attention of the social or health worker to the neglect of recognition of patterns of adaptation and/or reconstruction of a new life for the resident and family (Mailick, 1978;118).

Residual functioning and the assets of the individual and family should be encouraged and supported. It is hoped that the resident, as well as offspring, will view the experience of institutionalization, adaptation and change as
another of life's challenges rather than as a defeat. Initially, this may be difficult since new residents, for example, may test or explore their relationship with family. Guilt induced tactics may be utilized by a new resident to bond children or relatives to them, to reaffirm that he/she is still loved and not abandoned, or as a method of blame or punishment for placement in a facility.

On the other hand, relatives may feel guilt and pain in spite of knowing that placement is the only viable alternative. At the same time, they may initially have difficulty visiting or facing their aged relative due to the uncertainty of the reception they may receive, or because they find it difficult to see their parent living among debilitated or confused elderly.

Casework services and preparation of the individual and family can help to mediate between conflicting parties to facilitate reconciliation and the expression of feelings. It is also important for relatives and staff to understand that erratic or disruptive behaviour may be a reaction to admission or as a reflection of underlying family dynamics rather than interpreting the behaviour or attitude exhibited as a personal affront or as an inherent pattern of the individual.

Other coping behaviour may be evidenced in the individual's lack of identification with the communal group. For instance, he/she may tend to view his/her psycho-social
functioning, health, or situation as special or unique from others. The resident may over-compensate or justify his/her position by making derogatory, generalized, or over-exaggerated statements regarding the mental and physical deficiencies of the residential population. As a result, the individual may withdraw or make little effort to "fit in." Instead, the relocatee may rely heavily on favoured family members as primary sources of emotional and social support. The family, driven by guilt and distress, may reciprocate by increasing the frequency of visiting and over-responding to the dependency and demands being made by the aging resident. In most instances, family interaction should be encouraged. At the same time, however, health or social workers should attempt to ensure that visits are kept short in order to preserve individual and family resources.

Since research suggests that institutional care staff may promote dependency (Barton, Balter and Arzeck, 1980), it is important that care staff are aware of these findings in order to encourage independent behaviour.

The reactions and attitudes thus far described underscore the complexity and range of possible adaptive mechanisms and coping styles that may emerge during the first months of institutionalization. Although also limited in scope, perspectives of aging and social and personal adjustment, such as the classic "activity" or "disengagement"
theories, have been advanced to partially explain the complexity and variations of individual patterns of aging (Cavan, 1962; Cummings and Henry, 1961). However, the individual must be considered as unique within the context of a socio-environmental framework. A broader view is needed to begin to understand and determine problem areas (if such exist) that may require or yield to intervention.

The social worker's attention must encompass the family and other social networks as well as the physical environment and the individual. The focus of work during the "settling in" stage should be aimed at helping the new resident (presuming that he/she has family) to understand the impact of change and to begin to rebuild a new life while maintaining linkages with the past. In my opinion, it is advantageous to ensure that the interests and needs of the resident and family are being met in the institution and community.

Studies indicate that factors such as the degree of choice and participation have an effect on relocation outcome. As a result, the individual will need appropriate information to guide his action, a degree of autonomy to allow for the flexibility of options, and a maintenance of internal balance in order to allow the elder person to engage in purposeful activity and interaction if he so desires (White, 1974; Schulz and Brenner, 1977). The strengths and resources of the family, the health and psycho-
logical status of the individual, and a host of other factors will also have an effect on whether the individual adequately adapts to the new environment. The health worker's difficult task will be to select priorities, where the greatest potential for change may occur within an economy of action.

The provision of a variety of group work and treatment approaches have proved beneficial for even the most debilitated elderly (Brody, 1977). Establishing a resident's welcoming committee or a "newcomers club" may also help new residents establish contacts and/or provide vehicles for the expression and sharing of feelings. A variety of innovative and imaginative approaches are particularly needed during the post relocation period.

POLICY ISSUES

The process and stages of relocation as outlined have essentially been viewed from a personal and family perspective with implications for micro practice and intervention. However, under the current constraints and organization of the Long-Term Care program and health system in general, there are a number of policies and issues which parallel these stages, often posing obstacles or barriers to the successful outcome of relocating the elderly. Since the process of relocation cannot realistically be viewed in isolation from the bureaucratic and organizational structure, the balance of this paper will examine and recommend policy and changes that could facilitate effective relocation and outcome.
From a perusal of the literature concerned with the relocation stress and the negative effect of recent admissions, it has been demonstrated that the actual placement procedure (including application, assessment, selection and admission policies), the quality of the institutional environment, and the importance of the social worker and family — all have an effect and influence in the relocation process (Brody, 1977; Tobin and Lieberman, 1976; Townsend, 1962). Accordingly, these areas will be generally examined from a policy perspective.

A. Factors Influencing Placement

As mentioned previously, admission to a care facility is frequently arranged from an acute care, general or allied hospital. Usually, the physician in consultation with medical social workers and other personnel act as the "gatekeepers" to the institution (Brody, 1979:50). On the surface, this hierarchical system may appear reasonable. However, the initiation for placement often obscures underlying or more expedient motives such as political and organizational struggles, or more simply, reflects the shortage of acute care beds and/or a lack of other alternatives. Often application is made to institutions most likely to have an early vacancy rather than to facilities which may best provide the care and quality of environment the older individual requires if, indeed, institutional placement is the most suitable arrangement. This is especially true when an emergency or crisis situation exists.
The practice of choosing the most available facility also occurs in community placements. Although a medical social worker, or long-term care assessor is likely to be involved in the decision to apply for institutional care, usually their focus or attention rests with functional or practical planning rather than arrangements for after care needs. Given these factors, it is not surprising that there are a number of misplaced people who may negatively experience the impact of the move (Williams, et al., 1973). Add to this experience the generally assumed view seniors hold toward placement:

All old people — without exception — believe that the move to an institution is the prelude to death. . .(the old person) sees the move to an institution as a decisive change in living arrangements, the last change he will experience before he dies. . . .Finally, no matter what the extenuating circumstances, the older person who has children interprets the move. . . as rejection by his family. (Townsend, 1962:103)

Certainly, moving to an unsuitable or inappropriate facility would confirm and actualize an individual's worst fears and suspicions.

The impetus to develop interventive placement mechanisms is gaining credence not entirely based on humanitarian motives. Problems associated with human costs do not precede the rising financial costs of maintaining the acute care hospital and the growing proportion of the number of the very old who often take up acute care beds. The budget for health care services is the largest single item of
provincial expenditures. Over 7.2 percent of the Gross National Product of Canada was paid to health services in 1978 to 1979 (Arkinstall, March 19, 1981). This year, health expenditures will fall 25 million short of $2 billion, with hospital programs reaching $1,043 million (Bell, March 11, 1981). In comparison to the total population, the elderly have more than twice as many hospital stays, which are twice as lengthy as young people (Schwenger and Gross, 1980). As a result of rising costs, society cannot respond to all of the perceived needs and demands people may make. Assessments must be made concerning the amount of a society's resources devoted to the elderly and other disadvantaged groups relative to other endeavours and the way these resources should be allocated.

Unfortunately, health care has often favoured those populations who are well-provided for already. The frail elderly who are characterized by a lack of social, economic, and personal resources, often find that health care and other crucial services are unavailable or inaccessible. Many physicians, for example, prefer to deal with conditions that pose a diagnostic challenge and about which, they feel, they can do something. In contrast, the elderly do not as a rule respond well to medical treatment and may present psychological and psycho-social problems. Such problems, unlike technical procedures, are time-consuming and have uncertain outcomes. With the proliferation of technical and medical
knowledge, physicians often feel uncomfortable dealing with the individual in a social context. Similarly, few doctors consent to make night calls or home visits even in emergencies. These factors are particularly important when we consider the chronic health problems and limited mobility of the elderly. A similar failing on the part of physicians is evidenced in the care of the institutionalized elderly. Generally, the elderly may be short-changed in receiving entitled services.

The neglect of psycho-social aspects of the elderly are also evident at the time of application to an institution. Often, referral and placement involves a physician at some point. Eligibility for placement is often based on his/her recommendations or referral. As well, eligibility is made either by home evaluation, out-patient or in-patient assessment by a long-term care assessor. Often placement can be indiscriminately arranged or, according to the assessor's personal judgment, done without adequate information or preparation given to either the patient or family and, in a few instances, without the patient's informed consent.

Situations have arisen where a new resident suddenly arrives by taxi, or some other means, at the facility door with no family, no clothing, or personal effects, and no social history. In most cases, Long-Term Care assessment forms have been completed prior to admission, but they are often out of date and/or arrive days after the individual
has moved to the facility. (More than one Long-Term Care form has been lost or misplaced in the system.) In order to remedy this situation, several facilities have developed their own individual application form, thereby duplicating and increasing paper-work demands for health care staff and increasing frustrations for applicants and their families.

The process of application to homes for the aged is an example of a fragmented approach to placement, not only in British Columbia. According to Walter Lyons, director of the Baycrest Home in Toronto, the application process is superficial and fragmented "if it is primarily oriented to the individual while generally neglecting the social, cultural, and psychological components of the individual" (Lyons, 1966:5). Although psycho-social aspects may be acknowledged in written form, in actual practice, a medical model approach dominates: an approach modelled after short-term care, emphasizing illness, diagnosis and cure. Decision-making and eligibility has usually been determined by government supports which also control bed availability (Brody, 1975; Lefroy and Page, 1972). Similarly, reimbursement to facilities is usually paid for by physical illness and disability rather than for social and psychological services (Shore, 1976:2). The practice of inaccurate assessment of social, medical, and functional needs, as well as inadequate preparation and delivery of services, can negatively influence adjustment and life satisfaction for those entering institutional care.
Accordingly, a new formula which includes all aspects of systems supports, with a particular emphasis on the anticipated resources of the aged at risk, must be devised. Again, a systematic approach to assessment is also indicated before more facilities or services are planned. As well as measuring functional ability, assessment mechanisms should logically encompass the environmental supports of those seeking placement (family, friends, etc.), thus facilitating a better match of need to services (Brody, 1977).

Of course, assessments will only be as good as the staff who complete them. At the present time, assessments and placement are usually arranged by assessors who are not primarily trained in dealing in personal relationships. Long-Term Care's original scheme or proposal of having a multi-disciplinary team (including social workers) to assess, screen, and counsel individuals for entry to Long-Term Care facilities was never realized (possibly as a result of the unanticipated numbers who are applying for some type of service). However, it is imperative that a critical consideration of a team approach to assessment and placement should be revitalized and implemented by Long-Term Care policy makers. The institutions themselves also have an increasing responsibility and investment in promoting social and community supports for the institutionalized elderly.
B. Future Policy Directions

It should be kept in mind that often the elderly at risk in the community or in hospitals may manifest limited mobility and/or psycho-social functioning. Consequently, these individuals may not be able to actively seek or participate in locating institutional care. How can we ensure that the bedfast, housebound or confused and their families are involved in the relocation process? Most importantly, who can assist or help if family members are unavailable?

For example, the frail elderly in the community are difficult to detect since they do not necessarily come to the attention of an agency until a crisis arises. As well, the old person in need of protective services does not and often cannot seek the help he/she needs. Someone must go to them since their motivation for seeking help and using it is minimal (Hemmy, 1961:151).

As it exists now in British Columbia, there are few individuals providing services who remain constant in the lives of the elderly at risk in the community. The knowledge of whom to contact, where to send "mother", how to arrange moving, or how to handle crisis are areas that reflect insufficient staff and resources.

On a local level, the dissemination of information through the provision of printed material, news media, pictures, and so forth, might aid the elderly and their
families in the receipt of more accurate information and appropriate resources. A detailed local "shoppers" guide of facilities (such as those that are prepared now in many neighbourhoods) will ensure that people make more informed and appropriate facility selections. Not only the general public, but medical, nursing para-professionals and others, who are in contact with the elderly, could also benefit from an informative guide. Frequently, professionals and others have limited knowledge of local facilities and resources. At the same time, their role often requires a referral for services, an involvement in the decision-making and/or arrangements for placement. In my opinion, it seems imperative that health professionals and the community at large have easy access to accurate information in order to make more informed care and placement plans.

In British Columbia and elsewhere, new ideas and suggestions are presently being discussed to facilitate communication and linkages within the myriad of government agencies now in existence. Suggestions, such as a "facilitator" program or intermediary service to act as a referral system and provide actual integration and follow-up for the individual, are presently being considered. A component of such a program would include a single continuous contact (preferably a social worker) whom the elderly and their families could turn to for advice and support services. Possibly, facilitator services could operate from the local
long-term care offices or could be operated under voluntary or non-profit auspices or under an appointed board.

Often, the complexity of the health system, the fragmentation of service and the lack of adequate numbers of available long-term care staff may prevent the frail elderly from attaining entitled services. An intermediary service is needed to coordinate existing services on behalf of the elderly. Similarly, there is a further need to implement additional referral centres, counseling agencies and home rehabilitation services (occupational and physiotherapy) for seniors and their families.

C. Psycho-Social Assessment

At the present time, there are few hospital resources which focus on the continuity of care during treatment, on preparation for discharge, or in the provision of suitable after care.

In the hospital setting, for example, the elderly who have greater residual capacities and potential for improved psychological and physical functioning are often transferred to rehabilitation wards or hospitals. Eligibility criteria for more intensive treatment and therapy are often limited to those who may benefit the most in the least amount of time. However, for those elderly who have the greatest degree of disability, require more intensive care, and/or treatment, and who are likely awaiting placement for a nursing home bed, programs, treatment, and therapy are
either negligible or non-existent. Within the acute care hospital, more chronic care beds could be designated with the express purpose of improving or, at least, maintaining current functioning levels. The psycho-social components of care and rehabilitation could be administered primarily by para-professionals and, to a lesser extent, professionals. As a result, the elderly would have a greater and less pressured period of time to adjust and improve limited functioning, and/or to arrange an alternative plan for after care in their own homes or other housing.

In the present situation, elderly individuals are left to vegetate in hospital wards, lacking social stimulation, personal caring, and other essential basics for living. Certainly, blame cannot be placed with either medical or nursing staff since, in reality, they simply are not allowed the time to adequately attend to the psycho-social needs of those elderly awaiting placement.

Although the preceding proposal is a rather short-term solution to a long-term and complex problem, it was presented as an example of a variety of proposals that are currently being considered and discussed by service providers and planners in Canada and elsewhere.

In British Columbia, there are some recent developments of hospital programs which are geared to a concern of continuity of care during treatment and discharge. The geriatric in-patient assessment units at Mount St. Josephs and
the Jubilee Hospital in Victoria are recent examples of hospitals which contain a diagnostic, treatment, and discharge planning unit within an in-patient hospital framework. These serve not only individuals within the institutions, but also provide needed services for the community elderly as well. This type of approach, of comprehensive assessment and appropriate referral, has proven effective in matching the needs of the individual with the type of care and environment required.

At the same time, however, admission criteria is stringent since the centres accept only those elderly who exhibit "unexplained" confusion, sudden irrational or emotional behaviour, or a recent onset of a multiplicity of problems. Similarly, the elderly are admitted for a short or limited period of time lasting four to six weeks approximately. Since the criteria for admission is strictly monitored, it excludes a number of people who may benefit from the service. If possible, admission requirements should be more lax to encompass a wider range of the elderly population who may be prematurely admitted to institutions.

Another alternative is the day hospital, where patients who do not require twenty-four-hour care come to the facility in the morning and return to their primary residence in the evening after receiving medical care, rehabilitation and social services as needed. An increase in programs such as
these would have major benefits. First of all, "day care" is less disruptive and stressful than being admitted as a hospital in-patient. As well as receiving medical care and so forth, the individual's social needs and capabilities can be more accurately assessed to again facilitate a more appropriate and suitable environment to meet the individual's needs. These benefits could also be increased or expanded to facilities, families and other care providers of the elderly who have meager medical and professional resources. If we are interested in reducing relocation stress, then programs must be more accessible and available to a wider variety of elderly people. Development of outreach programs to bring these services to the elderly could also be considered by service providers.

Selection as a Basis for Policy

Certainly, not all elderly people suffer ill effects in relocating to institutions. Physical status, cognitive ability, and personality traits play a crucial role in outcome. Those who have an aggressive, narcissistic personality often fare better than the mentally impaired. The functionally disturbed and those with chronic brain syndrome, the physically ill, the depressed, hopeless, and those who use denial as a defense mechanism, have a greater risk of adverse effects (Aldrich, 1964; Aldrich and Mendkoff, 1963; Miller and Lieberman, 1965; Turner, Tobin and Lieberman, 1972).
Certain factors appear to relate to those who are most at risk and who may benefit from service intervention. Specific programs and services should be linked and provided to those most in need rather than attempting to service an entire elderly population who do not require services. Many people would say that the health system is oriented to providing expensive and highly technical care that appears inappropriate to health needs of the majority of the people. As well, it is often argued that possibly a third of the persons in nursing homes and long-term care facilities are not in need of expensive institutional care (Anderson, 1974: 522).

As a result of increasing costs and bed shortages, admissions to Vancouver and British Columbia care facilities are more strictly screened and bureaucratically regulated. Essentially, problems arising in Long-Term Care are clouded by the lack of clarity as to the target population and the kind of service to be afforded. If more stringent eligibility requirements include those elderly who are the most at risk in the community (i.e., the seriously confused, incontinent, or more physically impaired), the residential care facilities are likely to thwart these efforts by refusing or rejecting applicants on the basis of inadequate facility staffing, fiscal reimbursement and/or the convenience of the provider.
It should be mentioned that the facilities' refusal to accept certain applicants may, in fact, be realistic and valid. Staffing requirements, as determined by the Community Care Facilities Licensing Act (1979), are often inadequate to meet the needs of those individuals who require a greater degree of care or supervision. Variations within facilities, such as the range of care and services provided, the physical setting and other conditions, affect those who are accepted or rejected for admission. The increasing number of admissions of the psycho-geriatric patient often pose problems for service providers. Under the present system, if complex nursing procedures are not required, the patient is often not deemed as needing skilled care, and may be assessed at a relatively low level of care. Thus, the ambulatory but confused and impaired residents are not linked to the appropriate fee level in spite of the fact they require additional therapeutic and supervised care. For these people particularly, custodial approaches must be replaced by innovative, experimental, and optimistic treatment interventions.

Risk can be minimized by selecting an environment that agrees with the personal characteristics and functional abilities of the individual. The Philadelphia Geriatric Centre in Philadelphia, which fosters and rewards aggressiveness, found that aggressive personalities were conducive to the successful use of therapeutic programs (Kleban, Brody and Lawton, 1971). Additional studies support the importance
of matching a person and environment fit to help reduce the excess morbidity and mortality among the mentally and physically debilitated. Part of the rationale for supporting this notion is the belief that reducing environmental discontinuity will help to facilitate adjustment without relinquishing his/her personal coping style (Tobin and Lieberman, 1976:230). There is some question, however, as to whether differences in the pre- and post-environments make a difference for the most frail elderly and for whom relocation may have already exhausted and depleted personal resources (p. 230).

If certain personality traits such as aggression or assertiveness help to diminish relocation stress and mortality, possibly programs, medical and health care staff attitudes reflect these traits. This position has been advocated by others. Goldfarb (1974), for example, has implemented therapy designed to heighten the elderly's sense of mastery, a characteristic opposed to passivity. Seligman's classic work regarding "learned helplessness" also indicates or supports the need for interventions which mobilize psychological resources. Grant and Gutman's proposal (1980), cited earlier, also concur with the preceding objectives.

D. The Quality of the Institutional Milieu

Studies concerned with relocation stress and the elderly have indicated that not only the process of relocation, but the "quality" of the receiving environment affect the outcome
of those placed in institutions. Findings suggest a significant relationship between a positive outcome and such factors as: the degree of change incurred because of moving; the continuity of the previous lifestyle; the degree of preparation; opportunity for choice and independence; participation; medical status; the quality of the psycho-social milieu, including attitudes of residential staff and significant others; access for social interaction; community involvement, and so forth, (Marlow, 1973; Tobin and Lieberman, 1976; Noelker and Harel, 1976; Penning and Chappell, 1980).

While it is recognized that institutional residents require and deserve the most sophisticated medical, nursing, and para-medical services, it is also beyond question that attention to psycho-social needs are also critical to well-being. However, there is a great deal of current criticism that institutions are patterned after short-term acute care or the medical model. Although economics is one of the chief reasons for Long-Term Care, paradoxically, the use of the medical model has resulted in a series of inappropriate and costly consequences (Shore, 1976:73). Examples supporting this idea include the use of endless documentation of the patient's medical chart, and the use of employing medical and nursing staff to the exclusion of para-professionals or practitioners and others who have a psycho-social orientation. Often, evaluations of Long-Term Care have determined
that facilities have increasingly adopted a medical model of professionalization to a non-medical problem (Ministry of Health Task Force, 1980). Other evaluations advocate a blending and balance between social and health services, a psycho-social health model, which seems to be a more logical and appropriate position (Shore, 1976:70).

Part of the reasons for the conflicting opinions regarding the function and purpose of institutions arises from a lack of clarity, confusion and ambivalence regarding goals and philosophy. There is a lack of consensus, for example, about such basics as whether facilities should be primarily concerned with treatment, or just provide maintenance or custodial service to their clients (Ministry of Health Task Force, 1980). An opinion survey of British Columbia Health Association members varied greatly in their understanding of what the provincial philosophy for long-term care services were. Some said they were unaware there was any philosophy, while others believed that custodial care and placement were the primary objectives (Ministry of Health Task Force, 1980). Additional factors contributing to the confusion about nursing homes are the various types of ownership, and the various types of nomenclature (i.e., nursing homes, geriatric centres, levels of care; the variety and types of facility of design, etc.). As well, confusion has increased because of a lack of policy, cost factors, and inappropriate payment mechanisms, to name a few (Shore, 1976:71). Obviously, a clear and unified
but uncomplicated approach to care is urgently needed to provide the basis or groundwork for a continuum of quality care, including rehabilitation and other psycho-social components.

Ironically, although the social service aspects of care are often acknowledged in planning, the hierarchical nature of the health system often prevents successful implementation. For example, within the Long-Term Care system, a change in an individual's care level can result in a transfer to another ward or more often to another facility. An individual settled in a facility may find himself forced to move to a facility where his/her care needs can be met. The situation can become more distressing when a married couple is separated due to their differing care levels. Each may have to live in different facilities, sometimes miles from each other and their families. These difficulties could be partially remedied if facilities were built on a multi-level concept, offering a range or continuum of care.

Of the few multi-level facilities, one or two maintain two licenses: an Extended Care, and a Community Care Facility license (e.g., Louis Brier Home and Hospital in Vancouver, and the Priory in Victoria). Both licenses are provided under the Ministry of Health but within the jurisdiction of two different divisions of the Health Ministry. Each division has the responsibility for admitting residents
to their particular facilities through different channels. The local central registry in Vancouver admits residents to the Vancouver long-term facilities while a registry in Victoria specifically controls admissions to extended care hospitals. (It should be mentioned that the North Shore local Long-Term Care offices and other district offices arrange and list their own admissions to facilities within the limits of their jurisdiction or catchment area.) Consequently, extended care beds, for example, are not necessarily coordinated with the existing regional system, thereby creating unnecessary duplication, inefficiency, and a hindrance in the continuum of care.

Important as well is the fact that those elderly on waiting lists for long-term care or living in long-term care facilities, and who are now requiring extended care as a result of declining health, will receive no preferential treatment in terms of placement in an extended care facility. In spite of the fact that individuals have been in the Long-Term Care system for several months, they will receive no priorities by the extended care division to facilitate an earlier placement in an extended care bed. Therefore, they must wait up to a year or more for an extended care bed in addition to the length of time since they first applied for long-term care. In the interim, the elder persons may be forced to transfer and await placement in an acute care bed or, at the worst, may remain for an undetermined period of time in a facility not licensed for their individual care level.
Again, if the focus of Long-Term Care is to foster the well-being and adjustment of the elderly, Extended Care could logically be placed under the mandate of the Long-Term Care program. (At the least, Long-Term Care could control Extended Care admissions or a cooperative arrangement between the two divisions could be devised.) At this point in time, there appears to be a political or territorial struggle between the two divisions which is resistive to change. However, efforts should be made at integrating services in spite of the fact it may not seem popular or even possible.

The above discussion suggests first the importance of providing psycho-social services as well as medical needs, but not at the expense of one or the other. Secondly, since services are determined by fiscal policy and reflect attitudes and priorities of those in leadership positions, there is an urgency to review the health care system and ensure that meagre resources are distributed to those areas of care that produce the greatest benefit at the least cost. Thirdly, it is important that transitions between Extended-Care facilities and other institutions are coordinated to facilitate an efficient, organized and expedient transfer. An ideal fourth goal would be the construction of multi-level facilities in the future to prevent relocation of the elderly between institutions, and to accommodate couples who require differing levels of care. Generally, a realignment of the
health care system and a more progressive philosophy of goals and attitudes in combination with competence and commitment are needed. As well, greater awareness by the public might also help influence and improve the current health care system.

E. Social Supports and the Social Worker

The prospect of placement and admission of an older person in a long-term care facility is a painful, overwhelming psychological experience for the individual and family members of each generation.

Although family involvement should be encouraged from the time the elder person applies and continue for as long as the individual lives in the institution, the time of admission and the adjustment period are particularly crucial. Dr. Butler, director of the National Institute on Aging in the United States, suggests that homes for the aged could very shrewdly develop more effective relationships with the family at the time of admission so that a great deal of grief, guilt, and discomfort could be dealt with and, hopefully, dissipated (Butler, 1978:22).

Ironically, the strength of family ties has usually been overlooked in spite of the fact that family involvement from the beginning of application and throughout relocation can help to mitigate adjustment difficulties for the staff of the facility as well as the residents
A recurring view among practitioners is the idea that residential facilities should regard the family, as well as the resident, as clients. All need to be helped and supported through the trauma of the relocation process.

Several suggestions have been proposed and adopted by some facilities to work with the elderly and their families: (1) facility staff should involve themselves with families before and after admission and provide opportunities for them to join orientation and discussion groups with others who placed their parents in the facility; (2) qualified professionals, including social workers, should conduct the admission process, giving equal attention to family and new residents; (3) as a result of the guilt and anxiety evident at admission, families must be reassured regularly that they have reached the correct decision in choosing facility care; (4) facility staff should provide opportunities for families to play an active role in caring for the patient if they wish (Butler, 1978).

Basically, what is being suggested is a more integrated and encompassing approach to application and institutional services. For example, the application should be viewed as a plea for help. Time should be taken to understand the individual's problem while encouraging family involvement and discussion regarding possible alternatives to placement.
However, there is some question as to the degree or extent of responsibility that facilities should accept in terms of helpful involvement. If local Long-Term Care offices do not include counselling as a component of their mandate and hire few social work professionals, the facilities themselves should be held accountable for providing casework services. In addition, facilities are most likely to derive the greatest benefit from satisfactorily integrating the individual into the communal group (in terms of staff time and efficiency, resident satisfaction and adjustment).

In spite of professional consensus which states that the ratio should be one social worker for every fifty to sixty beds (Brody, 1979:55), and that social workers are an integral part of quality care, the Long-Term Care Program in British Columbia has not reflected these views. Although it was not the intent of the program that every facility would be able to provide all necessary professional services within its staff complement, in larger facilities it has been possible to either hire social workers or purchase services.

In British Columbia, however, smaller facilities can hardly afford this luxury, while only a few large facilities under non-profit or government auspices have a full-time paid professional social worker on staff. One facility with which I am familiar is the Jewish home and hospital for the aged, Louis Brier. In this facility, the social worker is involved
with the resident and family from the point of application and throughout the relocation process. Prior to admission, the social worker organizes family orientation meetings for residents, families and other relatives. At these sessions, relatives are able to vent frustrations, guilt, anger, and the whole complex of emotions between parents and children, and between siblings and relatives. An additional focus of the monthly sessions familiarizes relatives to institutional life and better prepares them for a range of affective behaviour or responses that may accompany the newly-admitted resident. The day the resident arrives at the facility, relatives are encouraged to help the relocatee unpack and generally get settled. In addition, staff invest time and energy to welcome newcomers, and generally encourage the participation and continued involvement of family members.

Part of the rationale for this approach rests on the assumption that the importance of contact cannot be equated with the quality and significance of strong emotional relationships. As Lowenthal and Havens (1968:30) have aptly expressed: "The maintenance of closeness with another is the centre of existence up to the very end of life." Accordingly, no bureaucracy and no array of interventional services can totally substitute for someone who cares and on whom one can depend.

In spite of the fact that many institutionalized elderly do have close supportive relatives, a large
percentage of elderly do not. The childless, single, divorced, and widowed are often over-represented in the institutional population. Of those who do have relatives, often these emotional ties are disrupted or weakened as a result of admission. For example, in his study of the institutionalized elderly, Townsend (1962:369) noted a marked decrease of social contacts attributed to geographic distances or location of facilities from the original home or relatives' home; to their infirmities; to the shortage of facilities; and to the inflexibility and characteristics of the facility. This author also noted that a large number of people were never visited and others did not have as much as one visit per week. Of interest also was the finding that only one resident in five made friends with other residents.

Although physical geography and so forth may tend to weaken filial ties, a recent study by Smith and Bengston (1979) questions the view that elderly persons in institutions are isolated from their families. Briefly, they found the opposite. Over half of the resident-family relationships examined experienced "renewed and strengthened closeness and a continuation of family closeness" (p. 444). The most common reasons given for these results were "the alleviation of pre-admission strains on the family caused by the multiple and acute needs of the parent" (p. 444). The authors felt the positive family consequence may have implications for
policy and practice. In view of the findings, they recom- 
mended that counselling of families following institu-
tionalization and the general incorporation of family 
members with the services provided for residents.

Although it would take relatively little additional 
money or staff to attend to the needs of residents' fami-
lies, the apparent lack of social workers in facility 
staffing exists in the method of funding, particularly for 
proprietary facilities. Present facility payment practices 
do not provide a financial incentive to hire social workers 
or other treatment oriented professionals since to do so 
would reduce their income or profit. Furthermore, the Adult 
Care Regulations permit the absence of such personnel.

Also of major importance is the present scheme of fee 
for levels of care. Under the present system, it has become 
financially more profitable to the proprietary facility owner 
to have residents deteriorate to higher levels rather than 
to promote adjustment and optimal functioning. Obviously, 
it is imperative that the financial arrangements and payment 
procedures to proprietary facilities should be changed. 
Facilities should receive fiscal reimbursement for those 
elderly who experience an increase in their level of func-
tioning. As well, staffing guidelines should be changed to 
promote the hiring of psycho-social professionals and para-
professionals as integral components for providing a better 
quality of life for elders spending their last years in an 
institution.
Paradoxically, these vital services: activity and recreational directors, chaplaincy personnel, social workers, and so forth, who are most important to the well-being of residents, are the ones least recognized by the government and the medical model.

At the same time, institutions are recognizing the value of providing more opportunity for interaction and contacts with families and the community at large. Louis Brier, for example, has arranged regular visits from school children, rabbis, ladies auxiliaries, volunteers, entertainers, and other interest groups. Other facilities are also leading the way in providing a stimulating and enriching social environment. For example, an Italian old age home in Toronto, Villa Colombo, has rented space to a nursery school in order to benefit both the old and the young. As well, the children and the elderly share meals and other events together. Other facilities, like the Priory in Victoria, Penticton and District's Retirement Complex, Baycrest and Maimonides in the east, also promote community interaction and involvement for their residents. As well, all of these homes ensure that residents participate in activities outside the institution.

In the last several years, there is a growing interest in facilities to provide a mix of services that include not only the maintenance of functioning, but also restorative, rehabilitative, and social services to promote the well-being
and life satisfaction of the institutionalized. Paralleling this trend, the community is in need of services that some institutions are in a position to provide. The role and function of the facility is subtly expanding, changing, and reaching out to the community. Most professionals have approved of this blending between community and institution.

A hopeful consequence of the inclusion of family and interest groups in institutional life would be the regulation of services offered and the general improvement in the quality of life. As one authority optimistically writes (Shanas and Sussman, 1973):

In some circumstances, by acting collectively for non-compliance or in proposing alternative methods of behavior, using techniques similar to those employed by bureaucracies, families can actively influence organizations and institutions to change their policies and practices.

IMPLICATIONS AND RECOMMENDATIONS

A. Policy

Some specific policy recommendations flow naturally from the preceding discussion. First of all, a more comprehensive assessment must be completed to include the psycho-social aspects of the individual. Instead of focusing on the medical and problem areas of the individual, the assessment should also encompass strengths, areas and concerns that are important to the individual. A more individualized and tailor-made assessment may prove useful for
the care providers and elder person once admitted to the institution.

Secondly, a multi-discipline approach to assessment and evaluation as originally conceived by Long-Term Care planners would also result in a more accurate and realistic care plan to match the individual with an appropriate environment as well as prevent premature institutionalization.

Thirdly, social casework services are necessary in assisting individuals and their extended families to cope with ensuing stress and disruption related to institutional placement. Larger facilities should include social workers and other therapeutic or rehabilitation disciplines as an integral part of their regular staff complement. Smaller facilities could share professional casework and rehabilitation services between them.

Fourthly, adequate and reasonable notice of a bed vacancy should be relayed to the prospective resident and their sponsors in order to ensure that they have the opportunity for a pre-placement facility visit and that arrangements for transfer can be efficiently organized in an unhurried manner.

Unfortunately, even if these recommendations were implemented, many of the difficulties inherent in the health care system concerning relocation and placement would remain.
A revamping or restructuring of Long-Term Care and the health system is essential if a more coordinated, continuous and effective approach to relocation is to be realized.

The present practice for placing patients and applicants in care facilities would be more effective and humane if planners would implement the development of a network of multi-level care facilities. Changes in residents' physical or emotional needs would then prevent a transfer from one facility to another more or less skilled nursing unit or facility. The development and expansion of multi-level care facilities would result in an improved continuum of care. Although some trauma invariably results in intra-institutional moves, it would not be as great as the disruption and stress resulting from transfers between institutions. Furthermore, there is a striking and obvious need for acute hospitals to provide additional beds and long-stay units for those elderly awaiting placement for institutional care. As well, long-stay units should be equipped and staffed with recreational and rehabilitative personnel to facilitate residual functioning, "capitalize on existing strength and replace psycho-social supplies" (Brody, 1975:474).

A similar suggestion for increasing the existing care levels of residential facilities and nursing homes would also help counteract the experience of relocation and living in an institution.
Most importantly, a coordinated, multi-discipline approach to create more humane transfer procedures between the long-term care facility and other institutions would also facilitate the preceding objectives.

Innovative and cost effective forms for providing long-term care services must be a primary focus of concern. Day-care, day hospitals and in-patient assessment units are a few of the more recent arrangements that could also be included as part of the multi-level facility concept to help provide easy access or linkages between the community and institutionalized elderly. In this way, more appropriate planning and the prevention of premature or unnecessary placement can be actualized and achieved.

Multi-service geriatric centres and/or facilitator programs are needed to provide ongoing and stable contacts to help coordinate and organize geriatric services, to provide a wide range of outreach services, and to reduce the dichotomy and fragmented approaches between institutional care and community home care services.

B. Practice

Experience in relocating the elderly throughout the process or stages of relocation, as previously outlined in this paper, indicates the excessive stress and demands that this stage of life holds for not only the elder person, but also for their families and other supports including
care providers in residential facilities and the community.

While it is recognized that relocation stress can escalate and often prove detrimental for older persons, it is also important to recognize that this population is not homogeneous and that many elders successfully survive and may benefit from facility care. However, for those who are seriously ill, debilitated mentally and physically, and have few personal resources, often institutionalization is the appropriate and only available alternative.

Of importance for social workers and health professionals is the acceptance of the elder person as a unique person with individual characteristics, assets, values, histories and expectations. Similarly, misconceptions, stereotypes and negative attitudes toward the aged, which conceive that work with the elderly is not challenging, interesting and worthwhile, is not founded on reality and does not reflect our current knowledge and experience. Assumptions of the Long-Term Care program and health professionals must include the acceptance that the elderly, like younger people, have the right to live the balance of their lives with dignity and maximum well-being. Moreover, the elderly have the potential for growth and change, and our institutional settings and health care system in general must provide not only the medical aspects of care, but also the provision of psycho-social components of care.
In view of the fact that relocation and increasing institutionalization is a growing concern, those involved with the care and planning for this population must have an understanding of not only aging and the relocation process, but must also be in touch with their own aging and how these attitudes may influence proposed priorities, program development and practice.

A "whole" person concept within the context of the family, community and society must be considered and emphasized from the point of initial application for service and, particularly, throughout the crucial first months after institutional admission. Careful consideration of the applicant, his social networks and supports may help identify issues and concerns necessary for adequate assessment, evaluation and adjustment to institutional living.

As illustrated in the early case study cited of a multi-generation family, it is important for the health worker to be alert or aware of the complexity of emotions, interactions and processes that are interwoven and may occur at each stage of the move. An awareness and sensitivity of intergenerational family dynamics, and an ability to identify resources, strengths and liabilities of both clients (the individual and family) will enable social workers and other professionals to contend with the ensuing stress that accompanies relocation.

While a personal bias towards a systems approach for working with the elderly has been advocated and found useful,
selective use of other interventions, such as pre- and post-orientation programs, individual and group therapy, and other innovative approaches can provide a viable alternative or supplement throughout the initial, middle and final phases of relocation.

As well, opportunities for participation and choice, the continuation of family and community involvement, adequate preparation, the preservation and respect for the individual's uniqueness, dignity and rights, are some of the factors found which help mitigate relocation stress.

Most people fight for their rights, but the elderly usually do not do so. Too often, they are excluded from decision-making regarding their lives. Instead of saying to the elderly, "Trust us, we know what is good for you," we should be asking their assistance and direction in planning for their future.

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The Age Composition of Vancouver’s Population

In April 1982, a Quarterly Review article reported that the number of residents in the city increased about one percent between 1976 and 1981, while the number of households increased by over eight percent. In the October issue, another article described changes in the density and spatial distribution of the city’s population. This article examines recently obtained data from the 1981 Census to describe and discuss significant changes in the age composition of the city’s population.

The Population Grows Older

While individuals grow older each year, a population can become younger if the number of younger people increases relative to the number of older people. In many countries of the world however, and particularly in their larger cities, populations are growing older as a result of declining fertility rates and longer life spans. This is the case in Vancouver and the surrounding metropolitan area, as well as throughout Canada.

A convenient way of comparing the age of two populations, or a population’s age at two points in time, is to examine median age. If all the people in any large gathering were lined up from the youngest to the eldest, the age of the person in the middle of the line-up would be the median age of the group.

Vancouver has an older population than the other cities and municipalities of the metropolitan area, as shown in Figure 1. However, this age difference has declined in the last decade as median age has increased throughout the metropolitan area. The median age of the city’s population increased from 33.6 in 1971 to 34.3 in 1981. The median age of the suburban population increased more rapidly with the result that a six-year difference in median age has shrunk to a three-year difference.

Age Composition Differences

The age composition of a population refers to the distribution of people among various age groups. Figure 2 shows the age composition of the city and surrounding suburban area. There are significant differences. The suburbs have a much greater proportion of children than the city does. About 30 percent of the suburban population is under 20 years of age as compared to 21 percent of the city population. The baby-boom generation, or those people in the 20 to 34 age group, is about 25 percent of the suburban population and about 30 percent of the city population. Both the city and suburbs have about 34 percent of their population between 35 and 64 years of age. The city has significantly more people aged 65 years and over, about 15 percent of its total population compared to 10 percent in the suburbs.